Optimal Performance Physical Therapy

Initial Examination

Name: _____ **Referral:** _____ **Date:** _____

General Demographics:

Date of Birth: _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

Race/Ethnicity: ☐ Asian ☐ Black ☐ Pacific Islander ☐ Latino
☐ Native American ☐ White ☐ Hispanic ☐ _____

Language: ☐ Speaks english ☐ Interpreter needed
☐ Speaks and Understan ☐ _____

Highest Level of Education: ☐ Grade School ☐ Technical School ☐ Some College ☐ Masters Degree
☐ High School ☐ Trade School ☐ College graduate ☐ _____

Hand/Foot Dominance: ☐ N/A ☐ Ambidexterous ☐ Left ☐ Right

Social History & living Environment:

Referral Source: _____

Where do you live? ☐ Private Home ☐ Rented Home ☐ Extended Care ☐ Hospice
☐ Apartment ☐ Homeless ☐ Board & Care ☐ _____

With whom do you live? ☐ Alone ☐ Relative(s) ☐ Friends ☐ Child or children
☐ Spouse ☐ Parent(s) ☐ Group setting ☐ _____
☐ Partner ☐ Brother(s) ☐ Sister(s)

Does your home have: ☐ One level ☐ Two levels ☐ Multi-levels ☐ Stairs, no railing
☐ Ramps ☐ Elevations ☐ Elevators ☐ Stairs, railing
☐ Uneven terrrain ☐ Any Obstacles (list): _____

How many steps: No. Steps outside the home: _____ No. Steps inside the home: _____

Do you use: ☐ Forearm Crutches ☐ Axillary Crutches ☐ Straight Cane ☐ Walker
☐ Manual Wheelchair ☐ Quad Cane ☐ Two Canes ☐ Rolling Walker
☐ Motor Wheelchair ☐ Glasses ☐ Hearing aids ☐ Other: _____

Cultural/Religious:

Any customs or religious beliefs or wishes that might affect care? _____

_____

_____

Social/Health Habits:

Do you Smoke Tobacco: ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

Do you Drink Alcohol: ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

Exercise (beyond normal daily activities & chores)? ☐ No ☐ Yes If Yes, How many days per week: _____ How many minutes per day: _____

Describe exercise or activity: _____

Employment/Work (Job/School/Play):

Work Status: ☐ Unemployed ☐ Working Full-time ☐ Working light duty ☐ Student ☐ Homemaker ☐ Working Part-time ☐ Disabled ☐ Retired

Occupation: _____

Your Work Involves: (Check all that apply)

☐ Prolonged Standing	☐ Working with a bent neck	☐ Lifting Light Objects
☐ Prolonged Sitting	☐ Frequent typing	☐ Lifting Heavy Objects
☐ Prolonged Walking	☐ Repetitive overhead work	☐ Carrying Light Objects
☐ Prolonged Driving	☐ Excessive reaching	☐ Carrying Heavy Objects
☐ Prolonged forward bending	☐ Frequent hand Grasping	☐ Repetitive pushing/pulling
☐ Exposure to vibrating tools	☐ Climbing ladders	☐ Repetitive arm motions
☐ Exposure to temperatures	☐ Excessive stair climbing	☐ Repetitive foot motions

☐ Other: _____

General Health Status:

Please Rate Your Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

Major life changes (past year): ☐ None ☐ Death in Family ☐ New Job ☐ Divorce ☐ New Baby

Family History - Please Check if Anyone in Your Family Has or Had Any or The Following:

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Psychological ☐ Pulmonary/Lung Disease

☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Osteoporosis ☐ _____

Past Medical History - Please check if you have or had any of the following (check all that apply):

☐ No Past Medical History	☐ Diabetes	☐ Genetic Disease	☐ Pacemaker
☐ AIDS	☐ Emphysema	☐ Kidney Disease	☐ Parkinson's Disease
☐ Asthma	☐ Epilepsy/Seizures	☐ Liver Disease	☐ Prostate Disease
☐ Arthritis	☐ Glaucoma	☐ Low Blood Pressure	☐ Skin Disorders
☐ Blood Disorders	☐ Heart Attack	☐ Lung Disorder	☐ Stroke
☐ Broken Bones	☐ Heart Disease	☐ Lyme's Disease	☐ Thyroid Disorder
☐ Circulation Problems	☐ Hepatitis	☐ Macular Degeneration	☐ Ulcers (stomach)
☐ Cancer	☐ Head Injury	☐ Muscular Dystrophy	☐ Repeated Infections
☐ Cystic Fibrosis	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ _____
☐ Depression	☐ High Cholesterol	☐ Osteoporosis	☐ _____

Past Medical History - For Women Only:

Pelvic Inflammatory Disease	☐ Yes	☐ No	**Trouble with Period**	☐ Yes	☐ No
Complicated Pregnancies	☐ Yes	☐ No	**Pregnant**	☐ Yes	☐ No
Endometriosis	☐ Yes	☐ No	☐ _____	☐ Yes	☐ No

Surgical History - Please list any surgeries you have had, and if known include dates:

☐ **No Surgeries to Date**

1. _____ **Date:** _____ **2.** _____ **Date:** _____

3. _____ **Date:** _____ **4.** _____ **Date:** _____

Past Symptoms History Checklist - Within the past year, have you had any of the following (check all that apply):

☐ No Symptoms in Past Year	☐ Difficulty Walking	☐ Joint pain or swelling	☐ Tremors
☐ Bowel problems	☐ Dizziness/Blackouts	☐ Loss of Appetite	☐ Urinary problems
☐ Chest Pain	☐ Excessive Sweating	☐ Loss of Balance	☐ Vision Problems
☐ Cough (persistent)	☐ Fatigue	☐ Nausea/vomiting	☐ Weakness in arms/legs
☐ Decreased coordination	☐ Headaches	☐ Numbness in arms/legs	☐ Weight gain (Unexplained)
☐ Difficulty Sleeping	☐ Hearing Problems	☐ Pain at Night	☐ Weight Loss (Unexplained)
☐ Difficulty Swallowing	☐ Heart Palpitations	☐ Shortness of Breath	☐ _____

Diagnostic Tests/Measures - Within the past year, have you had any of the following (Check all that apply):

☐ No Diagnostic Testing	☐ Bronchoscopy	☐ EMG/Nerve conduction	☐ Stool Test
☐ Angiogram	☐ CT Scan	☐ Mammogram	☐ Stress Test
☐ Arthroscopy	☐ Ultrasound	☐ MRI	☐ Urine Test
☐ Biopsy	☐ Echocardiogram	☐ Pap smear	☐ X - Ray
☐ Blood Test	☐ EEG	☐ Pulmonary Function Test	☐ _____
☐ Bone Scan	☐ EKG	☐ Spinal Tap	☐ _____

Medications & Allergies - Please check or list all medications or allergies:

Non-Prescription:

☐ No Medications	☐ Decongestants	☐ Motrin
☐ Advil/Alleve	☐ Excedrin	☐ Vitamins/minerals
☐ Antihistamines	☐ Herbal Supplements	☐ Tylenol
☐ Asprin	☐ Ibuprophen/Naproxen	☐ _____

Prescription: ☐ No Medications ☐ _____

Allergies: ☐ No Known Allergies To Date ☐ _____

Functional Status/Activity Level:

Current Functional Status:

Difficulty with locomotion/movement Such as: ☐ Bed Mobility ☐ Transfers (such as bed to chair, from bed to commode/toilet

☐ Gait (Walking) ☐ on level surfaces ☐ on ramps
☐ on stairs ☐ on uneven surfaces

Difficulty with self care activities such as: ☐ Bathing ☐ Dressing ☐ Toileting

Difficulty with home management such as: ☐ Household Chores ☐ Shopping ☐ Driving/Trasportation ☐ Care of Dependents

Difficulty with community and work activities such as: ☐ Work ☐ School ☐ Recreation ☐ Sport ☐ Play Activity

Prior Functional Status **(Your status prior to the date of onset/injury):**

Prior to your current injury or condition, were you pain free without any difficulty with locomotion/movement, self care activities, home management, community and work activities..... ☐ Yes ☐ No

If No, Please Explain: _____

Current Condition(s)/Chief Complaints:

Nature of Onset/Injury: ☐ Motor Vehicle Accident ☐ Fall ☐ Unknown Onset
☐ Work Related Injury ☐ Traumatic Event ☐ _____
☐ Gradual Onset ☐ Ongoing/Chronic Condition

Date of Onset: _____

Briefly Describe What Happened? _____

Chief Complaints or Problems? _____

Overall How Would You Describe the Intensity of your Symptoms? ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ Emergency

Overall, How Frequent Are Your Symptoms? ☐ Intermittent (off & on) ☐ Occasionally (sometimes) ☐ Constant (all the time)

Have you ever had this problem(s) before? ☐ Yes ☐ No **What did you do for the problem(s)?** _____

_____

Did the problem get better? ☐ Yes ☐ No **How long did the problem(s) last?** _____

What Makes Your Symptoms Worse? _____

What Makes Your Symptoms Better? _____

What is Your Goal For Physical Therapy? _____

Are You Seeing Anyone Else For Your Problem? ☐ Yes ☐ No **If Yes, Please Check all that Apply.**

☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Neurologist ☐ Podiatrist
☐ Family Doctor ☐ Orthopedist ☐ Massage Therapist ☐ Rheumatologist ☐ _____