HISTORY, PHYSICAL CONDITION, AND PLAN CHART

Answering the following questions will assist the therapist in providing a safe and effective treatment program:

Patient's Name: ______________________________ **Today's Date**: _________________

Age: ____________ Height: ___________ Weight: __________________

What problem(s) bring you here today? ____

When did the symptom(s) begin? ____

Have you had any therapies for this problem before: ❑ Yes ❑ No

If yes, where? ________________________________ When? __________________________

Have you had any surgeries associated with this problem ❑ Yes ❑ No

If yes, when? ________________________________ Type of surgery? ___________________

Have you had any X-rays, MRIs, nerve testing done recently? ❑ Yes ❑ No

If yes, when? ______________________________ Results? _____________________________

List all medications or supplements you are taking: ____

____

____

Do you have allergies or reactions to drugs/medications? ❑ Yes ❑ No

If yes, what? ____

Please mark appropriate answer if you have had or currently have any of the following:

High Blood Pressure	❑ Yes ❑ No	Diabetes:	❑ Yes ❑ No
If yes, under control?	❑ Yes ❑ No	If yes, Type:	❑ One ❑ Two
Heart Attack	❑ Yes ❑ No	Seizures	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Dizziness	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No	Headaches	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
Balance Problems	❑ Yes ❑ No	Arthritis	❑ Yes ❑ No
Kidney Problems	❑ Yes ❑ No	Cancer	❑ Yes ❑ No
Nervous Disorders	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Vision Problems	❑ Yes ❑ No	Metal Implants	❑ Yes ❑ No
Hearing Problems	❑ Yes ❑ No	Pregnancy	❑ Yes ❑ No
Thyroid Problems	❑ Yes ❑ No	Others (please describe)	
If yes,	❑ hyper ❑ hypo	____________________________________	

General Heath:

1. Have you had any illnesses recently? ____
2. Have you had any unexplained weight gain or loss? ____
3. Do you have any sores that have not healed? ____
4. Do you smoke? _____________ if so, how many packs/day: ______________________________
5. Has your Doctor placed any restriction with respect to cardiovascular or resistive exercise? ❑ Yes ❑ No

   If yes, please explain: ____

Work Environment: Does your job involve the following, please mark appropriate box?

- ❑ Prolonged sitting
- ❑ Prolonged standing
- ❑ Prolonged walking
- ❑ Lifting, bending, twisting, climbing
- ❑ Use of equipment; if yes, explain ______________________________

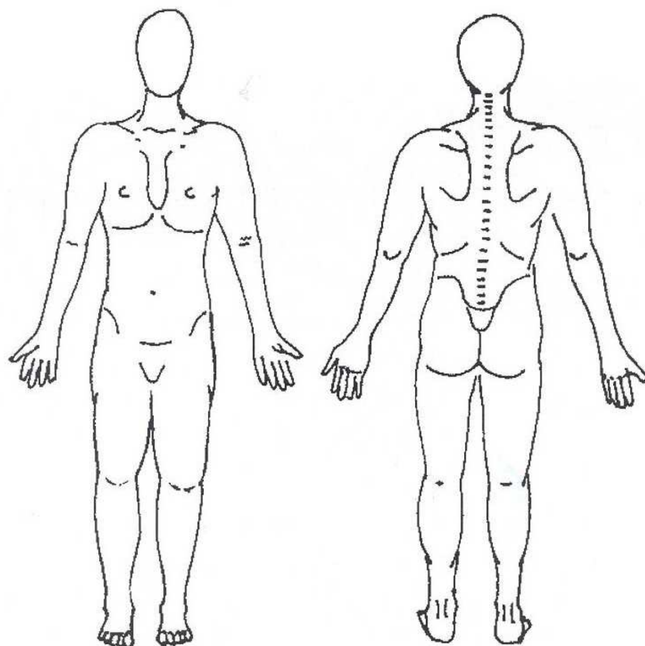
History of Falls: please mark appropriate box

- ❑ I have had no falls
- ❑ I have just started to lose my balance
- ❑ I fall occasionally
- ❑ Certain factors make me cautious (i.e. Curbs, ice, stairs)

Pain Questionnaire: On a scale from 0 to 10 (0 being no pain, 10 pain being excruciating pain)

What is your pain at best?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at worst?	0 1 2 3 4 5 6 7 8 9 10
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10

Indicate on the body diagram where you feel symptoms, use the key to indicate different types of symptoms: Please circle areas of pain



The above information is correct to the best of my knowledge:

Patient's Signature: ______________________________ Date: ____________

Therapist's Initials: ______________________________ Date: ____________