BECHTEL PHYSICAL THERAPY

To ensure you receive a complete and thorough evaluation, please provide the important, CONFIDENTIAL background information requested on this form. If you do not understand a question, your therapist will assist you. Thank you!

NAME: _____ **AGE:** _____

SS#: _____-_____-_____ **OCCUPATION:** _____

LEISURE ACTIVITIES: _____
_____
_____
_____

Are you currently seeing any of the following?:

A. Medical Doctor (M.D.)	Yes	No
B. Osteopath	Yes	No
C. Dentist	Yes	No
D. Psychiatrist/Psychologist	Yes	No
E. Physical Therapist	Yes	No
F. Chiropractor	Yes	No

If you have been seen by any of the above during the past three months, please describe for what reason (illness, medical condition, physical examination, etc.):

_____
_____
_____
_____

Have you EVER been diagnosed as having any of the following conditions?

A. Cancer	Yes	No
If Yes, describe what kind:		
_____		
B. Heart Problems	Yes	No
C. High blood pressure	Yes	No
D. Asthma	Yes	No
E. Emphysema	Yes	No
F. Chemical dependency (e.g., alcoholism)	Yes	No
G. Thyroid problems	Yes	No
H. Diabetes	Yes	No
I. Multiple sclerosis	Yes	No

J. Rheumatoid arthritis Yes No
K. Other arthritic conditions Yes No
L. Depression Yes No
M. Hepatitis Yes No
N. Tuberculosis Yes No
O. Stroke Yes No
P. Kidney disease Yes No
Q. Anemia Yes No
R. Epilepsy Yes No
S. Other: _____

Review of Systems: General Health

Do you have any of the following:

			Details
A. Fever/chills/sweats	Yes	No	_____
B. Unexplained weight change	Yes	No	_____
C. Malaise (extreme fatigue)	Yes	No	_____
D. Nausea/Vomiting	Yes	No	_____
E. Bowel dysfunction	Yes	No	_____
F. Numbness	Yes	No	_____
G. Weakness	Yes	No	_____
H. Syncope	Yes	No	_____
I. Dizziness/lightheadedness	Yes	No	_____
J. Night pain	Yes	No	_____
K. Dyspnea	Yes	No	_____
L. Dysuria (painful urination)	Yes	No	_____
M. Urinary frequency changes	Yes	No	_____
N. Sexual dysfunction	Yes	No	_____

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	**SURGERY/ HOSPITALIZATION/REASON**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

_____ _____

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	**INJURY**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Has anyone in your immediate family (parents, brothers, sisters, children) ever been treated for any of the following?

A. Diabetes	Yes	No
B. Tuberculosis	Yes	No
C. Heart disease	Yes	No
D. High blood pressure	Yes	No
E. Stroke	Yes	No
F. Kidney disease	Yes	No
G. Cancer	Yes	No
H. Arthritis	Yes	No
I. Anemia	Yes	No
J. Headaches	Yes	No
K. Epilepsy	Yes	No
L. Mental illness	Yes	No
M. Chemical dependency (e.g., alcoholism)	Yes	No

Which of the following OVER-THE-COUNTER medications have you taken in the past week?

A. Aspirin	Yes	No
B. Tylenol	Yes	No
C. Advil/Motrin/Ibuprofen	Yes	No
D. Laxatives	Yes	No
E. Decongestants	Yes	No
F. Antihistamines	Yes	No
G. Antacids	Yes	No

H. Vitamins/mineral supplements Yes No

I. Other: _____

_____

Please list any PRESCRIPTION medication that you are currently taking (including pills, injections and skin patches):

_____

_____

_____

_____

Please do not be offended by the following "lifestyle" questions. They are designed to provide information that can be important to your health care and safety. (And, all your answers are, of course, CONFIDENTIAL.)

How much caffeinated coffee or other caffeinated beverages (like tea or soda) do you drink per day?

_____

How many packs of cigarettes do you smoke a day?

None	_____	1 - 1.5	_____
0 - 0.5	_____	1.5 - 2	_____
0.5 - 1	_____	2 or more	_____

How many days per week do you drink alcohol?

None	_____		
0-1 days	_____	4 days	_____
1 day	_____	5 days	_____
2 days	_____	6 days	_____
3 days	_____	7 days	_____

If one drink equals one beer, one shot of alcohol or one glass of wine, how much do you drink in an average sitting?

_____

How many days a week do you use marijuana?

None	_____		
0-1 days	_____	4 days	_____
1 day	_____	5 days	_____
2 days	_____	6 days	_____
3 days	_____	7 days	_____

How many days a week do you use "recreational" drugs?

None	_____		
0-1 days	_____	4 days	_____
1 day	_____	5 days	_____
2 days	_____	6 days	_____
3 days	_____	7 days	_____