Physical Therapy Admission Information Form

HORIZON physical therapy and rehabilitation

Name: ____

Height _______ Weight ______ Age _______

Are you: ( ) Right-handed ( ) Left-handed

Education:

Highest grade completed (circle one): 1 2 3 4 5 6 7 8 9 10 11 12

- ☐ Some college/ technical school
- ☐ College school / Advance degree
- ☐ Graduate School/ Professional Degree

Employment:

- ☐ Working full-time outside of home
- ☐ Working full-time from home
- ☐ Working part-time outside of home
- ☐ Working part-time from home
- ☐ Homemaker ☐ Student
- ☐ Retired ☐ Unemployed

Occupation: ________________________

Where do you live?

____One Level home ____2 Level Home / apartment

____Mobile Home ____Multi Level Home

____Assisted living/group home/ Adult Foster Care

____Long-term care facility (nursing home)

Other: ____

With whom do you live?

- ☐ Alone ☐ Spouse only
- ☐ Spouse and children ☐ Parents
- ☐ Group setting ☐ other: _______________

Does your home have:

- ☐ Stairs, railing Y/ N
- ☐ Ramps
- ☐ Elevator
- ☐ Uneven Terrain
- ☐ Other______________________________________

Do you use:

- ☐ Cane
- ☐ Walker
- ☐ Manual Wheelchair
- ☐ Motorized wheelchair

General Health

Please rate your health:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any major life changes during the past Year? (such as a new baby, job change, death of a family member)

☐ Yes ☐ No

Health Habits

Do you exercise regularly? ☐ Yes ☐ No

If yes, how often and what type of activities?

____

Do you smoke?

☐ Yes ☐ No Year Quit: _________

Do you drink alcoholic beverages?

☐ No ☐ Occasional ☐ weekends ☐ daily

Medical History: Please check if you have ever had:

☐ Diabetes	☐ Kidney disease	☐ Head Injury
☐ Anemia	☐ Multiple Sclerosis	☐ Rheumatoid
☐ Arthritis	☐ Asthma	☐ Epilepsy
☐ Stroke	☐ Pacemaker	☐ Hepatitis
☐ Thyroid problems	☐ Heart problems	☐ Tuberculosis
☐ Cancer	☐ Depression / Anxiety	☐ Peptic Ulcer

- ☐ Emphysema/Bronchitis ☐ High blood pressure
- ☐ Balance or gait disturbance ☐ Bowel or bladder changes
- ☐ Other: ____

For Men:

Have you been diagnosed with prostate disease?

☐ Yes ☐ No

For Women:

Have you been diagnosed with:

Pelvic inflammatory disease?	☐ Yes	☐ No
Endometriosis?	☐ Yes	☐ No
Trouble with your period?	☐ Yes	☐ No
Complicated pregnancies?	☐ Yes	☐ No

Pregnant, or think you might be pregnant?

☐ Yes ☐ No

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe, and include dates:

	Month/Year
________________________________	____/______
________________________________	____/______
________________________________	____/______
________________________________	____/______

Within the past year, have you had any of the following symptoms? (Check all that apply)

☐ Bowel problems	☐ Hoarseness
☐ Chest pain	☐ Joint pain or swelling
☐ Coordination problems	☐ Loss of appetite
☐ Cough	☐ Loss of balance
☐ Difficulty sleeping	☐ Nausea/vomiting
☐ Difficulty swallowing	☐ Pain at night
☐ Difficulty walking	☐ Shortness of breath
☐ Dizziness or blackouts	☐ Urinary problems
☐ Fever/chills/ sweats	☐ Vision problems
☐ Headaches	☐ Weakness in arms or legs
☐ Hearing problems	☐ Weight loss/gain
☐ Heart palpitations	☐ other: _______________

Medications:

Do you take any medications? ☐ Yes ☐ No

If yes, please list:

Medication	Dosage	Frequency

☐Patient Provided List ___________

PT Initial

HORIZON
physical therapy and rehabilitation

Allergies:

Do you have any allergies? ☐ Yes ☐ No
If yes, please list:
____

Within the past year have you had any of the following medical Tests: (Check all that apply)

☐ X-rays ☐ Bone scan
☐ MRI ☐ Mammogram
☐ CT scan ☐ Arthroscopy
☐ Doppler ultrasound ☐ EMG (electromyogram)
☐ Stress test (e.g., treadmill, bicycle)
☐ NCV (nerve conduction velocity)

Current Limitation (Check all that apply)

☐ Difficulty with bed mobility
☐ Difficulty with transfers (moving from bed to chair, sofa to commode)
☐ Difficulty walking
___ on level surface ___ on stairs ___ on ramps
___ on uneven terrain
☐ Difficulty with self-care (such as bathing, dressing, eating, toileting)
☐ Difficulty with community and work activities/integration
☐ Difficulty work/school / recreation or play activity
☐ Difficulty with household chores, shopping, driving, laundry

History of Current Problem(s)

When did the problem(s) begin? ____/____/____
What happened?
____
____
____

Have you ever had similar problem(s) before?
☐ Yes ☐ No

What makes your problem(s) feel better?
☐ ICE ☐ Hot pack ☐ Rest ☐ Medication
☐ other____

What makes the problem(s) worse?
____

Are you seeing anyone else for this problem? (Check all that apply.)

☐ Acupuncturist ☐ Occupational therapist
☐ Cardiologist ☐ Orthopedist
☐ Chiropractor ☐ Osteopath
☐ Dentist ☐ Pediatrician
☐ Family physician ☐ Podiatrist
☐ Massage therapist ☐ Psychologist
☐ Neurologist ☐ Rheumatologist
☐ Gynecologist ☐ Speech Therapist
☐ Other: ________________

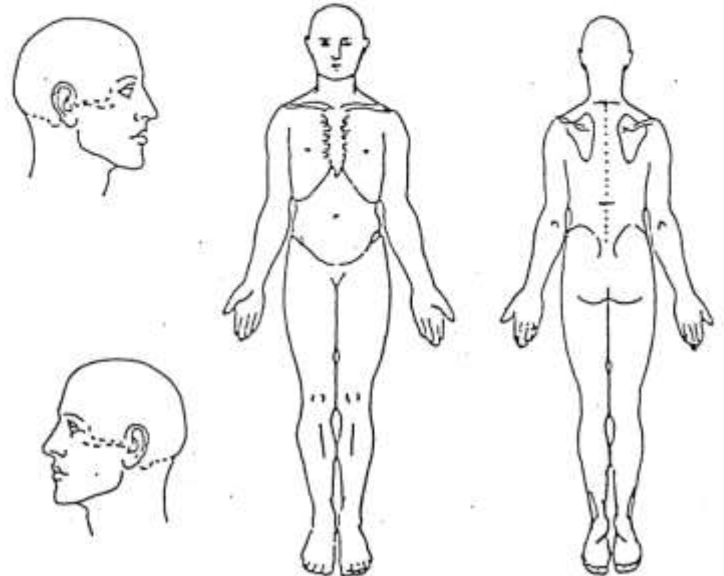
What activities are you not able to do now that you could do *before* the current problem(s)? ____________________________
____
____

What are your goals for Physical Therapy?
____

It is important that we have a measure of your pain. Please rate the level of your pain on the following scale.

At present:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
	(no pain)				(moderate pain)					(extreme agony)	

Please indicate painful areas by shading these models.



KEY

Numbness	= = = = = =
Pins & Needles	0 0 0 0 0 0
Burning Pain	XXXXXX
Stabbing Pain	/ / / / / / / / /

Which of these words describe your pain? (Circle all that apply)

Sharp Dull Burning Aching Tingling

Numb Constant Variable Radiating (moves)

Patient Signature: ________________________________

Physical Therapist: ________________________________
Dr. Jerome Adams PT DPT Date