**RIMS INDIA PVT.LTD**

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| **Name:** |  | **Referral:** |  | **Date:** |  |

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| **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 & Understand | | |  | | | |
| **Highest Level of Education:** | * Grade School | * Technical School | | * Some College | * Master’s Degree | | |
| * High School | * Trade School | | * College Graduate |  | | |
| **Hand / Foot Dominance:** | * N/A | * Ambidexterous | | * Left | * Right | | |

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| **Social History & Living Environment:** | | | | | | |
| **Referral Source:** |  | | | | | |
| **Where do you live?** | * Private Home | * Rented Home | | * Extended Care | * Hospice | |
| * Apartment | * Border | | * Homeless |  | |
| **With whom do you live?** | * Alone | * Relative(s) | | * Friend(s) | * Child or Children | |
| * Spouse | * Parents(s) | | * Group setting |  | |
| * Partner | * Brother(s) | | * Sister(s) |  | |
| **Does your home have?** | * One level | * Two level | | * Multi – level | * Stairs, no railing | |
| * Ramps | * Elevation | | * Elevators | * Stairs, railing | |
| Uneven terrain | 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 aid | * Others: | |
| **Cultural/Religious:** | | | | | | |
| Any cultural or religious beliefs or wishes that might affect care? | | | | | | |

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| **Social/Health Habits:** | | | | | | | | |
| **Do you Smoke Tobacco:** | * No | | | * Occasionally | * Socially | * Daily | | * Heavily |
| **Do you Drink Alcohol:** | * No | | | * Occasionally | * Socially | * Daily | | * Heavily |
| **Exercise:** | * No | | * Yes | If yes how many times per week: | | | How many minutes per day: | |
| **(Beyond normal daily activities & Chores)?** | | Describe exercise or activity: | | | | | | |

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| **Employment/Work (Job/School/Play):** | | | | | | |
| **Work status:** | * Unemployed | * Work full-time | | * Work light-duty | | * Student |
| * Homemaker | * Work part-time | | * Disabled | | * Retired |
| **Occupation:** |  | | | | | |
| **Your work involves:**  **(Check all that apply)** | * Prolonged Standing | | * Working with bent neck | | * Lifting light object | |
| * Prolonged Sitting | | * Frequent typing | | * Lifting heavy object | |
| * Prolonged Walking | | * Repetitive overhead work | | * Carrying light object | |
| * Prolonged Driving | | * Excessive reaching | | * Carrying heavy object | |
| * Prolonged forward bending | | * Frequent hand grasping | | * Repetitive pushing/pulling | |
| * Exposure to Vibrating tools | | * Climbing ladders | | * Repetitive arm motions | |
| * Exposure to temperature | | * Excessive stair climbing | | * Repetitive foot motions | |
| Other: | | | | | |

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| **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 |

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| **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 |  |

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| **Past medical history -** **Please check if anyone in your family has or had any or the following:** | | | |
| * 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 Disorder |
| * Blood Disorder | * Heart Attack | * Lung Disorder | * Stroke |
| * Broken Bones | * Heart Disease | * Lyme’s Disease | * Thyroid Disorder |
| * Circulation Problems | * Hepatitis | * Macular Degeneration | * Ulcers (Stomach) |
| * Cancer | * Head Injury | * Multiple Sclerosis | * Repeated Infections |
| * Cystic Fibrosis | * High Blood Pressure | * Osteoporosis |  |
| * Depression | * High Cholesterol | * Muscular Dystrophy |  |

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| **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 |

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| **Surgical History – Please list any surgeries you had, and if known include dates:** | | | |
| No surgeries to date | | | |
| 1. | Date: | 2. | Date: |
| 3. | Date: | 4. | Date: |

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| **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 arm/legs |
| * Decreased co-ordination | * 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 |  |

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| **Diagnostic Test/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 |  |

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| **Medications & Allergies – please check or list all medications or allergies:** | | | | |
| **Non - Prescription** | * No Medications | * Decongestant | | * Motrin |
| * Advil/Alleve | * Excedrin | | * Vitamins/minerals |
| * Antihistamines | * Herbal Supplements | | * Tylenol |
| * Asprin | * Ibuprophen/Naproxen | |  |
| **Prescription:** | * No Medications | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **Allergies:** | * No Known Allergies to date | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

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| **Functional Status/ Activity level:** | | | | | | | |
| **Current Functional Satus:** | | | | | | | |
| **Difficulty with locomotion/movement Such as:** | * Bed Mobility | * Transfers(such as bed to chair, from bed to commode/toilet)) | | * On ramps | | | |
| * On uneven surfaces | | | |
| * Gait (Walking) | * On level surfaces | | * On stairs | | | |
| **Difficulty with self-care activities such as:** | * Bathing | * Dressing | | * Toileting | | | |
| **Difficulty with home management such as:** | * Household Chores | * Shopping | * Driving/Transportation | | | * 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 the current injury condition, were you pain free without any difficulty with locomotion/movement, self-care activities, home, community and work activities………………….. | | | | | | | * Yes |
| * No |

If No, Please Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Condition(s)/Chief Complaints:

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| What Makes Your Symptoms Worse? | | |  | | | | |
| What Makes Your Symptoms Better? | | |  | | | | |
| What is Your Goal For Physical Therapy? | | |  | | | | |
| Are You Seeing Anyone Else For Your Problems? | | | * Yes | * No | | If Yes, Please Check all that Apply | |
| * Acupuncturist | * Cardiologist | * Chiropractor | | | * Neurologist | | * Podiatrist |
| * Family Doctor | * Orthopedist | * Massage Therapist | | | * Rheumatologist | |  |