Physical Therapy Adriana Lucía Ramírez Bonilla

Date: _____ Name: _____ DOB: _____ Age: _____
Occupation: _____ Work status: FT __ / PT__ / Retired __ / Not Working __
Primary Care Physician: _____
Please provide any results from recent x-ray, MRIs surgical pictures, surgical report or other test results:
Please answer as fully as possible.
What hurts? _____
Date symptoms began? _____
List any recent surgery: _____
What was the cause of your current problem?
_____
Have you had this before? _____ What helped you? _____
What are you doing to help yourself now?
_____
Did the problem come on immediately or gradually? _____
How has your problem changed over the last 14 days?
_____
What makes symptoms better? _____
What makes symptoms worse? _____
How do your symptoms change over the course of the day?
_____

Can you sleep through the night and how?
_____
What percentage of your normal functional ability are you at now? _____
Do you normally exercise and how?
_____
_____

Please indicate pain range on scale: From 0-10 (0= no pain, 10= excruciating pain, 5= moderate pain)

Your pain when you feel the best: ___/10
Your pain when you feel the worst: ___/10

Check any of the following which you **cannot do for 20 min** comfortably:

Sit		Walk		Normal work duties		Sleep		Housework	
Stand		drive		Carry 20 lbs (9 kg)		Use computer		Yardwork	

Check any of the following you cannot do with your normal ability:

Climb stairs		Move from sit to stand		Get in/out of the car	
Reach overhead		Move from floor to standing		Feed yourself	

Lift 5-10 lbs (2.5- 4.5 kg) overhead		Pick 10-20 lbs (4.5-9 kg) from floor		Use utensils	
Bathe and groom self		Move in bed		Chew	
Dress yourself					

Personal Medical History – Check and describe when applicable

	Yes	No	
Current infection			Describe:
Cancer			Describe:
Hospitalization last year			Describe:
Other			Describe:

	Yes	No
Heart Problems or pacemaker		
High Cholesterol		
Asthma		
Chemical Dependency		
Thyroid problems		
Multiple sclerosis		
Depression		
Tuberculosis		
kidney disease		
Epilepsy		
Osteoporosis		
Osteopenia		
Pregnancy		

	Yes	No
High blood pressure		
Circulatory problems		
Emphysema or bronchitis		
Smoking		
Diabetes		
Rheumatoid arthritis		
Other arthritic condition		
Metal Implants		
Hepatitis		
TIA/Stroke		
Anemia		
Allergies		
Heartburn or Acid reflux		
Intestinal or bowel problems		
Chicken pox, Shingles, Herpes		

Please rate the following:	0-never	1-several days	2-more than 50% of the time	3-daily
I've little interest or pleasure in doing things				
I often feel down, depressed or hopeless				

Have you recently noted any of these:

	Yes	No
Weight loss		
Nausea/vomiting		
Fatigue		
Weakness		
Fever/chills/sweats		
Numbness/tingling		

	Yes	No
Shooting pain in both arms and legs		
Persistent cough		
Dizziness		
Headaches		
Blurred vision		
Blood in stool		

Please list all medications you're currently taking:

Medication	Dosis	# times/day	Reason for medication

Have you discussed your medical condition with your doctor? _____

Signature (signed original)_____ Date _____

Printed name _____
Relationship (self, mother, dad, legal representative) _____