CARLISLE PLACE
PHYSICAL & OCCUPATIONAL THERAPY

Patient Medical History & Status

Patient Name: _____ DOB: _____/_____/_____ Age: _____

What is your current gender identity? ( ) M ( ) F ( ) Prefer not to say

What brought you to seek rehabiliation? _____

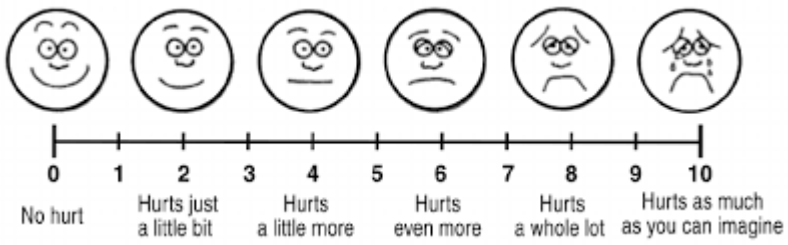
Have you seen a physican regarding the pain you are experiencing? ( ) Yes ( ) No

Does the pain you are currently experiencing limit your ability to care for yourself? ( ) Yes ( ) No

I began having pain/symptons on or about _____/_____/_____

I have had this condition (please circle): Never Unit Now Once Many Times Before Now

Please rate your pain level using the tool provided:



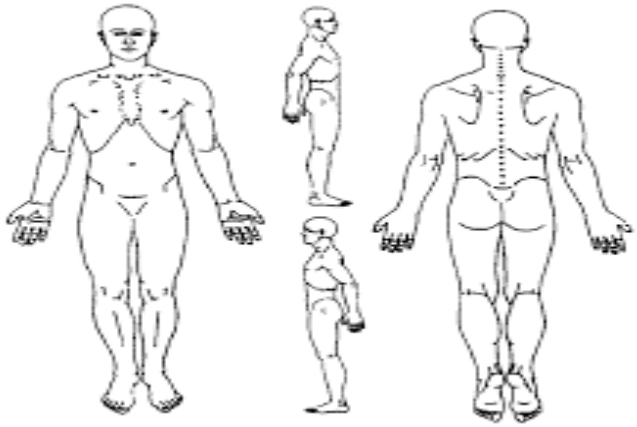
At Worse: _____/10

Current: _____/10

Best: _____/10

Please mark the area of pain or discomfort on the chart provided, using the appropriate symbols:

Burning: ^^^^^
Dull/Achy: +++++
Sharp: xxxxx
Throbbing: ooooo
Shooting: →→→
Numbness/Tingling: =====



My pain is (please circle):

Constant Intermittent

Circle below the activity and/or activities that make your pain worse:

Sitting Standing Walking Bending Stairs Transfers Squatting Kneeling Lying down Driving

Dressing Cooking Cleaning Reaching overhead Reaching behind back Lifting objects Gripping objects

Other: _____

Circle below what eases your pain:

Ice Heat Rest Stretching Therapy Medication Lying down Standing Sitting Bending

Other: _____

Explain what activities you are having difficulty doing because of your pain or dysfunction:

_____

_____

Have you had or are you scheduled for diagnostic imaging (i.e. X-ray, MRI, Nerve Conduction Study, etc)? ( ) Y ( ) N

If yes, please explain: _____

_____

Currently I am experiencing (check all that apply):

( ) Appetite has changed
( ) Difficulty swallowing
( ) Headaches
( ) Nausea/vomiting
( ) Unexplained weight loss
( ) Bowel/bladded function has changed
( ) Dizziness
( ) Increased appetite at night
( ) Numbess/tingling
( ) Other: _____
( ) Depression
( ) Fever/chills/sweats
( ) Muscular dystrophy
( ) **S**hortness of breath

Are you currently taking any medication (if Y**ES** please list):

_____

_____

Have you fallen over the past **12** months? ( ) Yes ( ) No If yes**,** how many times? _____

Is this in**j**ury related to an auto accident? ( ) Yes ( ) No

Did this in**j**ury happen at work? ( ) Yes ( ) No

If work related**,** do you currently have a Workers **C**ompenstation claim open? ( ) Yes ( ) No

Current Personal Information

I am living (check all that apply)**:** ( ) Alone ( ) Alone but with assistance for my needs ( ) With an adult(s)
( ) With children in the home**.** Ages _____

I am currently (check all that apply): **( ) E**mployed**;** my **j**ob is: _____
( ) I am unemployed ( ) I am retired ( ) I am on sick leave
( ) I am on disability ( ) I am applying for disability
( ) I work inside the home

My physical activites include (check all that apply):

( ) **R**eading, watching T**V**
( ) Walking, gardening, housework, occasional physical exercise
( ) **R**egular physical exercise at least twice per week

Past Medical History

Have you ever had physical or occupational therapy before? ( ) Yes ( ) No
If yes, explain: _____
_____
_____

Have you ever had surgery? ( ) Yes ( ) No If yes, date of surgery: _____/_____/_____

Type of surgery: _____

Do you <u>now</u> have or have you <u>ever had</u> any of the following conditions (check all that apply):

( ) Alzheimers	( ) Cardiovascular disease	( ) Cauda Equina Syndrome
( ) Current Infection	( ) Diabetes type **1**	( ) Diabetes type **2** (adult onset)
( ) Fibromyalgia	( ) Fracture or suspected fracture	( ) High blood pressure
( ) History of cancer	( ) Huntington's disease	( ) Immunosupression
( ) **L**upus	( ) Muscular dystrophy	( ) Obesity
( ) Osteoarthritis	( ) Pace Maker	( ) Parkinson's
( ) **R**heumatoid arthritis	( ) Tramatic brain in**j**ury	( ) Other: _____

Is there any other information or concerns you would like to share with your therapist? _____

_____

What is your personal goal for physical/occupational therapy? _____

_____

To our patients: Although many of these **q**uestions may not seem relevant to your visit today. We ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal in**j**uries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for you overall wellbeing and health.

Patient Name (printed): _____ Date: _____/_____/_____

Patient **S**ignature: _____

Self-reported or functional index score: _____/_____

Oswestry **C**ervical Index DA**S**H **LEFS** DHI FOTO P**R**W**E** U**E**F**S** Other:_____

Therapist **S**ignature: _____ Date: _____/_____/_____