LSUHSC Physical Therapy Clinic

Name: _____ SSN: _____ Date: _____

Leisure Activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ Height: _____ Weight: _____

Are you on a work restriction from your doctor? ☐ Yes ☐ No Are you latex sensitive? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weight loss/gain
- ☐ Muscle weakness
- ☐ Falls
- ☐ Difficulty maintaining balance while walking
- ☐ Numbness or tingling
- ☐ Dizziness/lightheadedness
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Changes in bowel or bladder function
- ☐ Constipation
- ☐ Diarrhea
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cough
- ☐ Headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Bone or joint function
- ☐ Depression
- ☐ Chemical dependency(i.e. alcoholism)
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Rheumatoid arthritis
- ☐ Other arthritic condition
- ☐ Bladder/urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease/HIV
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple sclerosis
- ☐ Epilepsy
- ☐ Eye problem/infection
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Diabetes
- ☐ Stroke
- ☐ depression
- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Blood clots

During the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

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What date (roughly) did your present symptoms start? _____

What do you think caused the symptoms? _____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

Treatment received so far for this problem (chiropractic, injections, etc.): _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc.): _____

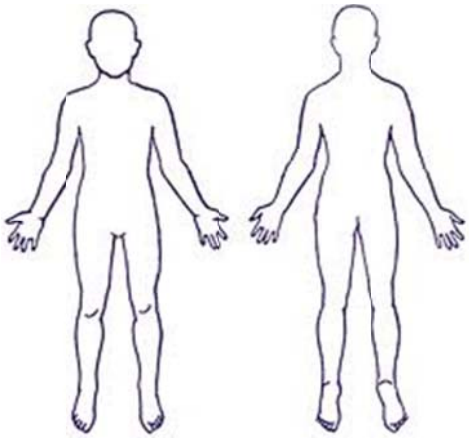
Have you ever had this problem before: ☐ Yes ☐ No When: _____ Treatment received: _____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/sharp pain
O Dull/aching pain
‖ Numbness
= Tingling



My symptoms currently: ☐ Come and go ☐ Are constant ☐ Are constant, but change with activity

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1._____
2._____
3._____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1._____
2._____
3._____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise
When are your symptoms best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

Using the 0 to 10 scale, with 0 being "no pain" and 10 being "worst pain imaginable" please describe:

Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____