GENESIS Physical Therapy

Patient Name: _____ **Preferred name:** _____

Email: _____ **Preferred phone # contact:** _____

Are you presently receiving any HOME HEALTH SERVICES (nursing, therapy, aide)? [ ] No [ ] Yes

Have you had any of the following in the last year?

[ ] Physical Therapy [ ] Occupational Therapy
[ ] Speech Therapy [ ] Chiropractic care [ ] Acupuncture [ ] Other: _____

Chief complaint(s): (Check all that apply)

[ ] Balance problems	[ ] Dizziness	[ ] Joint stiffness	[ ] Pain
[ ] Burn	[ ] Falls/History of falls	[ ] Joint swelling	[ ] Problems breathing
[ ] Cough	[ ] Fatigue/Poor endurance	[ ] Muscle tenderness	[ ] Tingling
[ ] Difficulty walking	[ ] Headache	[ ] Muscle weakness	[ ] Wound/skin condition
[ ] Difficulty w/ daily activities	[ ] Impaired sensation	[ ] Numbness	[ ] Other:_____

If you indicated pain, specify body part & location(s) of pain: (Check all that apply)

[ ] Ankle pain □ L □ R	[ ] Foot pain □ L □ R	[ ] Knee pain □ L □ R	[ ] Shoulder pain □ L □ R
[ ] Back pain □ L □ R	[ ] Hand pain □ L □ R	[ ] Leg Pain □ L □ R	[ ] Arm pain □ L □ R
[ ] Chest pain □ L □ R	[ ] Hip pain □ L □ R	[ ] Neck pain □ L □ R	[ ] Wrist pain □ L □ R
[ ] Elbow pain □ L □ R	[ ] Jaw pain □ L □ R	[ ] Rib pain □ L □ R	

Please indicate the intensity of your pain (0 = no pain 10= worst pain imaginable)

Pain at its BEST

0 1 2 3 4 5 6 7 8 9 10

Pain at its WORST

0 1 2 3 4 5 6 7 8 9 10

PRESENT

0 1 2 3 4 5 6 7 8 9 10

What makes your pain worse: _____

What makes your pain better: _____

Working Status: [ ] Full-time [ ] Part-time [ ] Retired [ ] Disability [ ] Unemployed [ ] Student

Name of employer and job title/position: _____

Briefly describe work duties: _____

Smoking and Tobacco use can delay tissue and bone healing. Do you currently use tobacco products?

[ ] Yes [ ] No

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

[ ] Arthritis
[ ] Asthma
[ ] Blood disorders
[ ] Broken bones/fractures
[ ] Cancer: Type: _____
[ ] Circulation/vascular problems
[ ] COPD
[ ] Deep vein thrombosis / PE
[ ] Depression
[ ] Development/growth problems
[ ] Diabetes
[ ] Eating Disorder
[ ] Emphysema
[ ] Fibromyalgia
[ ] GERD/Acid Reflux
[ ] Head injury
[ ] Headaches
[ ] Heart Attack/MI
[ ] Heart Disease
[ ] Hearing impairment
[ ] Hypercholesteremia (high cholesterol)
[ ] Hypertension (high blood pressure)
[ ] Infectious disease (TB, hepatitis)
[ ] Kidney problems
[ ] Liver disease
[ ] Low back pain
[ ] Low blood pressure
[ ] MRSA
[ ] Multiple sclerosis
[ ] Muscular dystrophy
[ ] Obesity
[ ] Osteoporosis
[ ] Parkinson disease
[ ] Peripheral Neuropathy
[ ] Psychiatric Disorders
[ ] Repeated infections
[ ] Seizures/epilepsy
[ ] Sleep apnea
[ ] Spinal cord injury
[ ] Skin diseases
[ ] Stomach problems/ulcers
[ ] Stroke
[ ] Thyroid problems
[ ] Vision impairment
[ ] VRE
[ ] Other: _____

Select all surgeries you have had: (Check all that apply)

[ ] ACL repair/reconstruction: □ Left □ Right
[ ] Achilles tendon repair: □ Left □ Right
[ ] Appendectomy
[ ] Arthroscopic surgery: Type: _____
[ ] Back surgery
[ ] Bone marrow transplant
[ ] Bunionectomy
[ ] Caesarian section
[ ] Cardiac surgery: Type: _____
[ ] Carpal tunnel release □ Left □ Right
[ ] Chondroplasty
[ ] Colon surgery
[ ] Colostomy bag
[ ] Femoral popliteal bypass
[ ] Gall bladder surgery/removal
[ ] Gastric Bypass/Lapband surgery
[ ] Hand surgery: □ Left □ Right
[ ] Hernia repair
[ ] Hysterectomy
[ ] Joint replacement: □ Shoulder □ Hip □ Knee □ Other
[ ] Lung surgery
[ ] Lumpectomy
[ ] Mastectomy
[ ] Neck surgery
[ ] Organ transplant: □ Heart □ Liver □ Lung □ Other
[ ] Pacemaker/Defibrillator
[ ] Plastic surgery
[ ] Rotator cuff repair: □ Left □ Right
[ ] Spinal or bladder stimulator
[ ] Splenectomy
[ ] Tracheostomy
[ ] Transurethral Resection of the Prostate
[ ] Other: _____

Do you have any of the following metal or plastic in your body? [ ] No [ ] Yes

If yes, Check all that apply:

[ ] Rods [ ] Pins [ ] Staples [ ] Artificial Joints [ ] Metal from gunshot
[ ] Other: _____

Have you ever had any allergies to materials or medication?

[ ] Yes [ ] No * - **If yes, please list:** _____

Are you taking any prescription, over-the-counter medications or herbal supplements?

[ ] Yes [ ] No * - **If Yes, provide a list to photocopy, or complete Patient Medication List (attached)**

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

[ ] Angiogram	[ ] EEG (electroencephalogram)	[ ] Pap smear
[ ] Blood tests	[ ] EKG (electrocardiogram)	[ ] Pulmonary function test
[ ] Bone scan	[ ] EMG (electromyogram)	[ ] Spinal tap
[ ] CT scan	[ ] Mammogram	[ ] Urine tests
[ ] Colonoscopy	[ ] MRI	[ ] VNG (Videonystagmograph)/ENG
[ ] Doppler ultrasound	[ ] Myelogram	[ ] X-rays
[ ] Echocardiogram	[ ] NCV (nerve conduction velocity)	[ ] Other: _____

To the best of my ability, I have included all pertinent medical information.

Patient/Guardian signature: _____ **Date:** _____

Medical history reviewed by clinician and used in determining the plan of care.

Clinician signature: _____ **Date:** _____ **Time:** _____