mobilization
physical therapy

PATIENT INFORMATION

First Name _____ MI_____ Last _____

Preferred Name _____ Date of Birth____/_____/_____ Age _____

Gender_____ Today's Date_____ Profession _____

Street Address_____

City_____ State_____ Zip Code_____

Primary Phone _____home/cell/work

Alternate Phone _____home/cell/work

Email Address_____

How would you like to receive courtesy appointment reminders? email / phone / text / decline

Emergency Contact Name_____ Phone_____

Relationship to Emergency Contact _____

How did you hear about Mobilization PT? _____

Primary Care Provider_____ Office Location _____

Primary Concern for Seeking PT _____

_____ Date of onset _____

Was the onset related to a specific incident? Y / N. If Yes, please describe: _____

_____

Are the symptoms staying same / getting worse/ getting better? (circle one)

Please rate your pain, if present, on a scale 0-10 (0= no pain, 10= emergency room) _____

Have you had an x-ray, MRI, or other imaging recently? Y / N. If Yes, please describe:

_____

Have you tried other treatments? Y / N. If yes, please describe: _____

_____

What aggravates symptoms? _____

What relieves your symptoms? _____

What was your lifestyle (sports, hobbies, etc) prior to this injury/pain? _____

_____

How has your lifestyle been altered because of this? What are your treatment goals?_____

_____

_____

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Patient Name_____

DOB_____

MEDICAL HISTORY

Since the onset of current symptoms, have you developed any of the following?

- ☐ Fever/chills
- ☐ Change in bowel function
- ☐ Change in bladder function
- ☐ Numbness/tingling
- ☐ Unexplained weight change
- ☐ Night sweats
- ☐ Dizziness or fainting
- ☐ Profound fatigue
- ☐ Unexplained weakness
- ☐ Nausea/vomiting
- ☐ Blood in urine or stool
- ☐ Swelling or lumps
- ☐ Difficulty swallowing
- ☐ Difficulty speaking
- ☐ Jaw Pain
- ☐ Teeth grinding
- ☐ Cough
- ☐ Skin Rash
- ☐ Falls
- ☐ Vision changes
- ☐ Hearing changes/tinnitus

Please check any conditions you currently have or have ever had (explain more below):

- ☐ Allergies to food/medications (list below)
- ☐ Eating disorder
- ☐ Hypoglycemia
- ☐ Angina or chest pain
- ☐ Epilepsy/Seizures
- ☐ Hypo- or hyperthyroid
- ☐ Anxiety/panic attacks
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Joint Replacement
- ☐ Anemia
- ☐ Fracture
- ☐ Latex Sensitivity
- ☐ Arthritis
- ☐ GERD/ulcers
- ☐ Multiple Sclerosis
- ☐ Asthma
- ☐ COPD or other breathing problems
- ☐ Gout
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Migraines/headaches
- ☐ Parkinson's
- ☐ Chemical Dependency (drugs/alcohol)
- ☐ Heart problems
- ☐ Pelvic Pain
- ☐ Chronic Fatigue Syndrome
- ☐ Hepatitis
- ☐ Cirrhosis/liver disease
- ☐ Kidney disease
- ☐ Scoliosis
- ☐ High blood pressure
- ☐ High Cholesterol
- ☐ Sexual or physical abuse
- ☐ Sleep Apnea
- ☐ Diabetes Type I or II
- ☐ HIV/AIDS
- ☐ Stroke
- ☐ Hearing loss/problems
- ☐ Vision/eye problems
- ☐ Urinary Problems
- ☐ Other:_____

For any checked above, please describe further _____

_____

Do you have a pacemaker, transplanted organ, or implant? Y / N _____

Female OB/GYN History: # vaginal deliveries _____ # cesarean deliveries _____

Irregular Cycle Y / N Menopause Y / N Incontinence Y / N Prolapse Y / N

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MEDICAL HISTORY (cont'd)

Surgical history & approximate date (include minor procedures, e.g. wisdom teeth or appendix):

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Medications: Please list all prescriptions, vitamins, supplements or OTC and reason for taking:

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Lifestyle

Sleep hours/night _____ Is your sleep disrupted by your symptoms?_____

Are you on a special diet? Y / N _____

How many alcoholic drinks do you consume per week? _____

Do you consume caffeine daily? Y / N Do you smoke tobacco? Y / N

Current level of stress (please circle): High Medium Low Is this stress chronic? Y / N

What do you do to relieve stress? _____

Physical Activity

1. On average, how many **days per week** do you engage in moderate to vigorous physical activity? (Moderate: can talk, but cannot sing, like brisk walking or easy bike riding; Vigorous: cannot talk and are somewhat out of breath, like jogging or tennis): _____
2. On average, how many **minutes per day** do you engage in this type of activity? _____

   ***Total minutes per week of physical activity (multiply #1 x #2) _____
3. How many **days per week** do you perform strengthening exercises, such as bodyweight exercises or resistance training? _____
4. How many **days per week** do you perform flexibility or mobility exercises? _____
5. How many **days per week** do you perform balance exercises? _____

Signature_____ Date _____