Excel Physical Therapy
"A Passion for Caring, a Reputation for Results"

## Physical Therapy Health Survey

***Excel Physical Therapy***
***3140 West Ward Road Suite 203***
***Dunkirk, MD 207543027***
**Phone:** ***410-286-7205***
**Fax:** ***833-268-8390***

At Excel Physical Therapy, we use a variety of procedures and modalities to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain, injury or may aggravate existing conditions. You have the right to decline any portion of your treatment at any time before or during your treatment session.

**I acknowledge that my treatment program will be explained by my therapist at Excel Physical Therapy, and all my questions will be answered to the best of their ability. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.**

_____ _____ _____

Signature of Patient or Parent/Guardian Date Relationship to Patient

_____

Printed Name of Patient

The information provided in this questionnaire is true and complete to the best of my knowledge. I understand that the accuracy of the information I have provided is important in order to develop an individualized plan of care for me.

_____ _____ _____

Signature of Patient or Parent/Guardian Date Relationship to Patient

_____

Printed Name of Patient

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**Medications – This information is required by Medicare and some private health plans.**

**Please use the chart below to list any over the counter and/or prescription medications you are currently taking (pills, injections, and/or skin patches). Include vitamins, supplements, and herbals as well as over the counter pain relievers.**

**If you have nothing to report please initial here.**

_____I do not regularly take any form of prescription or over the counter medications or supplements.

**If you have a list, we are happy to make a copy.**

| Medication/Supplement | Dosage | Frequency | Route Method |
|---|---|---|---|
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Please list any medication(s) you are allergic to and/or other allergies:

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**Are you Latex sensitive?** ☐ Yes ☐ No

*Initial and Date monthly and make any changes to your medications list:*

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

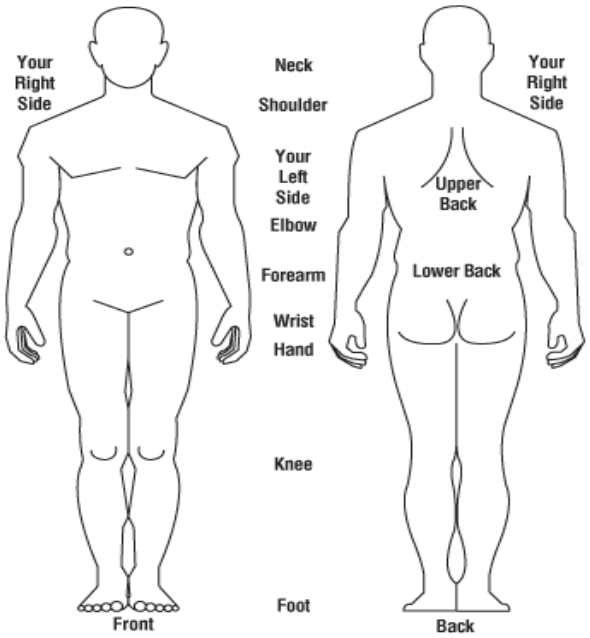
**Use a circle to rate your pain at present on the 0-10 pain rating scale below:**

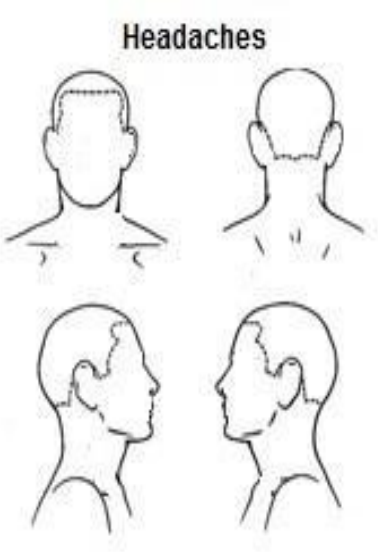
**0 1 2 3 4 5 6 7 8 9 10**

[No Pain] [Mild Pain] [ Moderate Pain] [ Pain is Severe] [Worst Pain Imaginable]

**Rate your pain on a scale of 0-10 at BEST and at WORST: Best_____Worst_____**

**Pain Chart:** Mark the areas on the diagram(s) below that coincide with your symptoms. Include all affected areas. Indicate radiating pain by drawing an arrow (□) from the origin of your pain to where it stops.



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**To ensure you receive a thorough evaluation, please provide us with the following information:**

**Occupation:** _____ **Do you commute?** ☐ No ☐ Yes,

**Hours per week:**

**Does your job involve:**☐ Sitting, How long?_____☐ Standing, How long?_____

☐ Walking ☐ Bending/Squatting☐ Lifting. weight required:_____☐ Reaching

☐ Climbing/Stairs

**Do you live alone?** ☐ Yes ☐ No

**Are you the primary caregiver for someone else?** ☐ Yes ☐ No

**Do you have stairs in your home?** ☐ No ☐ Yes, How many/location:

**Leisure Activities:**

**Have you had any of the following not related to the reason for today's visit:**

☐ Fracture ☐ Dislocation ☐ Sprain ☐ Metal implant ☐ Other injury

*Please describe with approximate date(s):*

**List any other surgeries, hospitalizations or major medical events not related to today's visit, including the approximate date:**

**What are your goals from physical therapy?**

**Have you ever smoked cigarettes or used other tobacco products**? ☐ Never ☐Yes (please answer below)

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**Have you smoked/used in the past 30 days?** ☐No ☐Yes (if yes, please continue below)

**On average, how many times do you smoke/use per day?**_____

**How long have you been smoking/using at that rate?**_____

**What relieves your symptoms?** (check all that apply) ☐ nothing ☐ rest ☐ heat ☐ cold ☐ splint/orthosis ☐ lying down ☐ sitting ☐ standing ☐ stretching ☐ walking ☐ exercise ☐ massage ☐ medication ☐ Other (Please describe):_____

**What aggravates your symptoms?** (check all that apply) ☐ sitting ☐ standing ☐ walking ☐ lying down ☐ rising from sitting ☐ squatting ☐ going up/down stairs ☐ reaching ☐ taking a deep breath ☐ stress ☐ coughing/sneezing ☐ sustained bending ☐ repetitive activity ☐ household activity ☐ work activity

☐ Other (Please describe):_____

**Have you had any falls in the last year?** ☐ NO ☐ Yes – How many falls in the past 12 months? ____

Were you injured as the result of a fall in the past 12 months? ☐ NO ☐ Yes

**Have you ever been diagnosed with any of the following conditions?**

☐ Asthma ☐ Depression ☐ HIV* ☐ Fibromyalgia ☐ Blood clots ☐ Diabetes ☐ Kidney Disease*☐ Stomach ulcers ☐ Cancer*☐ Heart Problems*☐ Multiple Sclerosis ☐ Stroke ☐ Chemical dependency☐ Hepatitis* ☐ Osteoporosis ☐ Thyroid Problems ☐ Circulation problems ☐ High blood pressure ☐ Other arthritic condition ☐ Tuberculosis ☐ Other*

*If you have answered yes to cancer, heart problems, kidney disease or other, please describe:

**Have you had physical therapy or other care for any orthopedic/musculoskeletal**

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**conditions? ☐Yes ☐No**

**Please tell us about any other orthopedic or muscular conditions you have/have had.**

**Have you had any x-rays, scans or neurological tests (for any condition)?** ☐ Yes ☐ No

Please list test(s) and location(s):

**Specialist/Referring Physician/Practice name and location:**

**Primary Care Physician Name/Practice name:**

Date of last physical examination: _____

Patient's height and weight:_____

**Reason for today's visit**:

**Because of this condition have you visited any of the following professional providers** (check all that apply)

☐ Primary Care Provider ☐ Orthopedic/Sports Medicine Doctor ☐ Pain Management Services

☐ Neurologist ☐ Chiropractor ☐ Oral Surgeon/Orthodontist ☐ Physical or Occupational Therapist

☐Other_____

**When did your symptoms begin?** _____ Was the onset ☐ Sudden ☐ Gradual

Any previous episodes? ☐ No ☐ Yes, please describe with symptoms, how it resolved, and date(s)

**Since the start of this episode are your symptoms** ☐ improving ☐ not changing☐ worsening

**Nature of your symptoms (check all that apply)** ☐ sharp ☐ dull ☐ throbbing ☐ aching ☐

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periodic ☐ nervy ☐ pins & needles ☐ occasional ☐ constant ☐
other_____

**As the day progresses do your symptoms: (check one)**

☐ increase ☐ decrease ☐ remain the same

**Do your symptoms wake you at night?** ☐ Yes ☐ No

In what position do you sleep? (check all that apply) ☐ back ☐ side ☐ stomach ☐ chair/recliner