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

Physical Therapy Health Survey

Name:_____ DOB:_____

Specialist/Referring Physician/Practice name and location: _____

Primary Care Physician Name/Practice name: _____

Reason for today's visit:_____

Date of surgery or onset of symptoms:_____

Any previous episodes? ☐No ☐Yes, please describe with symptoms, how it resolved_____

_____

1) 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 ☐Other_____

2) Have you had any x-rays, scans or neurological tests (for any condition)? ☐Yes ☐No
Please list test(s) and location(s):

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

5) Have you had physical therapy or other care for any orthopedic/musculoskeletal conditions? ☐Yes ☐No
Please tell us about any other orthopedic or muscular conditions you have/have had.

Medical History

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

☐Asthma	☐Depression	☐HIV*	☐Fibromyalgia
☐Blood clots	☐Diabetes	☐Kidney Disease*	☐Stomach ulcers
☐Cancer* Type:_____	☐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:

 Initial and Date _____ _____

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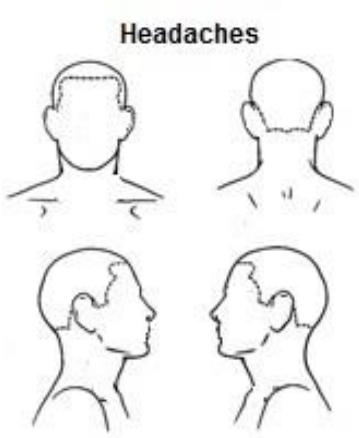
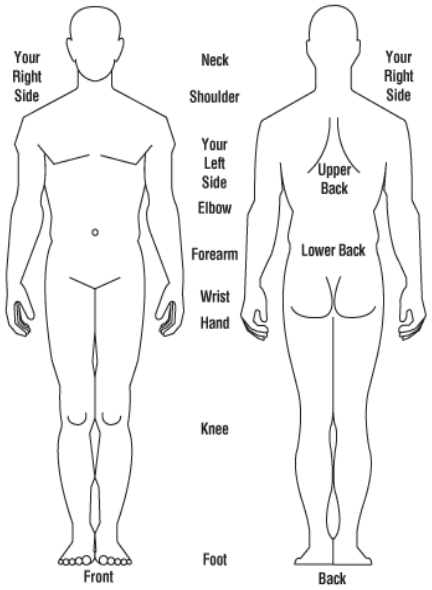
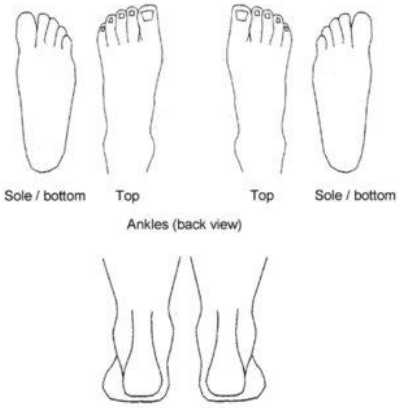
Pain Assessment

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.







1) Describe your pain: ☐sharp ☐dull ☐throbbing ☐aching ☐periodic ☐nervy ☐pins & needles ☐occasional ☐constant ☐other_____

2) Rate your pain level using the scale 0-10 (10 being worst pain): Current pain: ____ Worst pain:____ Best pain: ____

3) Since the start of this episode are your symptoms: ☐improving ☐not changing ☐worsening

4) As the day progresses do your symptoms: (check one) ☐increase ☐decrease ☐remain the same

5) Do your symptoms wake you at night? ☐Yes ☐No

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

7) What relieves your symptoms? (check all that apply) ☐nothing ☐rest ☐heat ☐cold ☐splint/orthosis ☐lying down ☐sitting ☐standing ☐stretching ☐walking ☐exercise ☐massage ☐medication ☐other

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

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Medication

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	Delivery Method

Please list any medication(s) you are **allergic** to and/or other allergies:

Are you Latex sensitive? ☐Yes ☐No

Social History

1) Living Situation: ☐Home ☐Parents ☐Assisted Living Facility ☐Lives with family ☐Lives with caregiver ☐Alone

2) Are you the primary care giver for someone else?☐Yes ☐No

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

4) Leisure Activities/Hobbies :_____

Employment History

1) Are you employed? ☐No ☐Yes If yes, Name of Occupation:_____

(select one) ☐Full time ☐Part time ☐Light duty ☐Out of work ☐Retired

2) Do you commute? ☐No ☐Yes If yes, hours per week:_____

3) Does your job involve: ☐Sitting, how long?_____ ☐Standing, how long?_____

☐Walking ☐Bending/Squatting ☐Lifting ☐Reaching ☐Climbing stairs

4) Work Description:_____

5) Is this workman's comp ☐No ☐Yes If yes, Date of injury:_____ Out of work since:_____

6)Is this a result of a motor vehicle accident ☐No ☐Yes If yes, Date of injury:_____

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What are your goals from physical therapy?

Consent to Treat

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 certify to the best of my knowledge the above information is correct. I understand I will be provided with a description of my individualized physical therapy treatment plan. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I have read and understand the above information and agree to consent to physical therapy treatment to be provided by Excel Physical Therapy personnel.

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

Signature_____
Date_____

Parent/Guardian (if under 18 years of age)_____ ___
Date_____

 Initial and Date _____ _____