Simons Physical Therapy

To ensure you receive a complete and thorough evaluation, please provide us with important background information on this form. If you do not understand a question, your therapist will assist you. Thank you.

NAME: _____ PRONOUNS: _____ OCCUPATION: _____

LEISURE ACTIVITIES/HOBBIES: _____

EMERGENCY CONTACT: _____ PHONE NUMBER: _____

Have you seen a physician for any of the following?

- ☐ Yes ☐ No Cancer, if yes describe what kind: _____
- ☐ Yes ☐ No Heart problems
- ☐ Yes ☐ No Circulation problems
- ☐ Yes ☐ No High Blood Pressure
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Emphysema/Bronchitis
- ☐ Yes ☐ No Chemical Dependency
- ☐ Yes ☐ No Thyroid problems
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Multiple sclerosis
- ☐ Yes ☐ No Rheumatoid arthritis
- ☐ Yes ☐ No Osteoporosis
- ☐ Yes ☐ No Other arthritic conditions
- ☐ Yes ☐ No Depression
- ☐ Yes ☐ No Hepatitis
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Kidney disease
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Epilepsy/seizures

Please list any surgeries or other conditions for which you have been hospitalized for, including the approximate date and reason for the surgery or hospitalization:

DATE	SURGERY/HOSPITALIZATION	REASON

Please describe any injuries for which you have been treated (including fractures, dislocations, sprains and the approximate date of injury):

DATE	INJURY	DATE	INJURY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Tuberculosis
- ☐ Yes ☐ No Heart disease
- ☐ Yes ☐ No High blood pressure
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Kidney disease
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Arthritis
- ☐ Yes ☐ No Anemia
- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Epilepsy
- ☐ Yes ☐ No Mental illness
- ☐ Yes ☐ No Alcoholism (chemical dependency)

Which of the following **over the counter** medications have you taken in the last week?

- ☐ Yes ☐ No Aspirin
- ☐ Yes ☐ No Tylenol
- ☐ Yes ☐ No Advil/Motrin/Ibuprofen
- ☐ Yes ☐ No Laxatives
- ☐ Yes ☐ No Decongestants
- ☐ Yes ☐ No Antihistamines
- ☐ Yes ☐ No Antacid
- ☐ Yes ☐ No Vitamins/Mineral supplements
- ☐ Yes ☐ No Other_____

Please list any PRESCRIPTION medication(s) you are currently taking: _____
_____
_____

How many glasses of water do you drink / day? _____
How many caffeinated coffee or caffeine containing beverages do you drink / day? _____
Do you smoke? _____ If YES what do you smoke and how much? _____
_____

How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink in a sitting? _____
Have you recently noted?

- ☐ Yes ☐ No Weight loss/gain
- ☐ Yes ☐ No Nausea/vomiting
- ☐ Yes ☐ No Fatigue
- ☐ Yes ☐ No Weakness
- ☐ Yes ☐ No Fever/chills/sweat
- ☐ Yes ☐ No Numbness/tingling
- ☐ Yes ☐ No Night pain

_____ _____
Patient's Signature Date