# Garden Ridge Physical Therapy

## Initial Examination

**Name:** _____ **Referral:** _____ **Date:** _____

### General Demographics:

**Date of Birth:** _____ **Age:** _____ **Sex:** ☐ Male ☐ Female

**Race/Ethnicity:** ☐ Asian ☐ Black ☐ Pacific Islander ☐ Latino
☐ Native American ☐ White ☐ Hispanic ☐ _____

**Language:** ☐ Speaks english ☐ Interpreter needed
☐ Speaks and Understan ☐ _____

**Highest Level of Education:** ☐ Grade School ☐ Technical School ☐ Some College ☐ Masters Degree
☐ High School ☐ Trade School ☐ College graduate ☐ _____

**Hand/Foot Dominance:** ☐ N/A ☐ Ambidexterous ☐ Left ☐ Right

### Social History & living Environment:

**Referral Source:** _____

**Where do you live?** ☐ Private Home ☐ Rented Home ☐ Extended Care ☐ Hospice
☐ Apartment ☐ Homeless ☐ Board & Care ☐ _____

**With whom do you live?** ☐ Alone ☐ Relative(s) ☐ Friends ☐ Child or children
☐ Spouse ☐ Parent(s) ☐ Group setting ☐ _____
☐ Partner ☐ Brother(s) ☐ Sister(s)

**Does your home have:** ☐ One level ☐ Two levels ☐ Multi-levels ☐ Stairs, no railing
☐ Ramps ☐ Elevations ☐ Elevators ☐ Stairs, railing
☐ Uneven terrrain ☐ Any Obstacles (list): _____

**How many steps:** No. Steps outside the home: _____ No. Steps inside the home: _____

**Do you use:** ☐ Forearm Crutches ☐ Axillary Crutches ☐ Straight Cane ☐ Walker
☐ Manual Wheelchair ☐ Quad Cane ☐ Two Canes ☐ Rolling Walker
☐ Motor Wheelchair ☐ Glasses ☐ Hearing aids ☐ Other: _____

**Cultural/Religious:**

Any customs or religious beliefs or wishes that might affect care? _____

## Social/Health Habits:

**Do you Smoke Tobacco:** ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

**Do you Drink Alcohol:** ☐ No ☐ Occasionally ☐ Socially ☐ Daily ☐ Heavily

**Exercise** (beyond normal daily activities & chores)? ☐ No ☐ Yes If Yes, How many days per week: _____ How many minutes per day: _____

Describe exercise or activity: _____

## Employment/Work (Job/School/Play):

**Work Status:** ☐ Unemployed ☐ Working Full-time ☐ Working light duty ☐ Student ☐ Homemaker ☐ Working Part-time ☐ Disabled ☐ Retired

**Occupation:** _____

**Your Work Involves:** (Check all that apply)

| | | |
|---|---|---|
| ☐ Prolonged Standing | ☐ Working with a bent neck | ☐ Lifting Light Objects |
| ☐ Prolonged Sitting | ☐ Frequent typing | ☐ Lifting Heavy Objects |
| ☐ Prolonged Walking | ☐ Repetitive overhead work | ☐ Carrying Light Objects |
| ☐ Prolonged Driving | ☐ Excessive reaching | ☐ Carrying Heavy Objects |
| ☐ Prolonged forward bending | ☐ Frequent hand Grasping | ☐ Repetitive pushing/pulling |
| ☐ Exposure to vibrating tools | ☐ Climbing ladders | ☐ Repetitive arm motions |
| ☐ Exposure to temperatures | ☐ Excessive stair climbing | ☐ Repetitive foot motions |

☐ Other: _____

## General Health Status:

**Please Rate Your Health:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Don't Know

**Major life changes (past year):** ☐ None ☐ Death in Family ☐ New Job ☐ Divorce ☐ New Baby

## Family History - Please Check if Anyone in Your Family Has or Had Any or The Following:

☐ Heart Disease ☐ High Blood Pressure ☐ Cancer ☐ Psychological ☐ Pulmonary/Lung Disease

☐ Diabetes ☐ Arthritis ☐ Stroke ☐ Osteoporosis ☐ _____

## Past Medical History - Please check if you have or had any of the following (check all that apply):

| | | | |
|---|---|---|---|
| ☐ No Past Medical History | ☐ Diabetes | ☐ Genetic Disease | ☐ Pacemaker |
| ☐ AIDS | ☐ Emphysema | ☐ Kidney Disease | ☐ Parkinson's Disease |
| ☐ Asthma | ☐ Epilepsy/Seizures | ☐ Liver Disease | ☐ Prostate Disease |
| ☐ Arthritis | ☐ Glaucoma | ☐ Low Blood Pressure | ☐ Skin Disorders |
| ☐ Blood Disorders | ☐ Heart Attack | ☐ Lung Disorder | ☐ Stroke |
| ☐ Broken Bones | ☐ Heart Disease | ☐ Lyme's Disease | ☐ Thyroid Disorder |
| ☐ Circulation Problems | ☐ Hepatitis | ☐ Macular Degeneration | ☐ Ulcers (stomach) |
| ☐ Cancer | ☐ Head Injury | ☐ Muscular Dystrophy | ☐ Repeated Infections |
| ☐ Cystic Fibrosis | ☐ High Blood Pressure | ☐ Multiple Sclerosis | ☐ _____ |
| ☐ Depression | ☐ High Cholesterol | ☐ Osteoporosis | ☐ _____ |

## Past Medical History - For Women Only:

| | | | | | |
|---|---|---|---|---|---|
| **Pelvic Inflammatory Disease** | ☐ Yes | ☐ No | **Trouble with Period** | ☐ Yes | ☐ No |
| **Complicated Pregnancies** | ☐ Yes | ☐ No | **Pregnant** | ☐ Yes | ☐ No |
| **Endometriosis** | ☐ Yes | ☐ No | ☐ _____ | ☐ Yes | ☐ No |

## Surgical History - Please list any surgeries you have had, and if known include dates:

☐ **No Surgeries to Date**

**1.** _____ **Date:** _____ **2.** _____ **Date:** _____

**3.** _____ **Date:** _____ **4.** _____ **Date:** _____

## Past Symptoms History Checklist - Within the past year, have you had any of the following (check all that apply):

| | | | |
|---|---|---|---|
| ☐ No Symptoms in Past Year | ☐ Difficulty Walking | ☐ Joint pain or swelling | ☐ Tremors |
| ☐ Bowel problems | ☐ Dizziness/Blackouts | ☐ Loss of Appetite | ☐ Urinary problems |
| ☐ Chest Pain | ☐ Excessive Sweating | ☐ Loss of Balance | ☐ Vision Problems |
| ☐ Cough (persistent) | ☐ Fatigue | ☐ Nausea/vomiting | ☐ Weakness in arms/legs |
| ☐ Decreased coordination | ☐ Headaches | ☐ Numbness in arms/legs | ☐ Weight gain (Unexplained) |
| ☐ Difficulty Sleeping | ☐ Hearing Problems | ☐ Pain at Night | ☐ Weight Loss (Unexplained) |
| ☐ Difficulty Swallowing | ☐ Heart Palpitations | ☐ Shortness of Breath | ☐ _____ |

## Diagnostic Tests/Measures - Within the past year, have you had any of the following (Check all that apply):

| | | | |
|---|---|---|---|
| ☐ No Diagnostic Testing | ☐ Bronchoscopy | ☐ EMG/Nerve conduction | ☐ Stool Test |
| ☐ Angiogram | ☐ CT Scan | ☐ Mammogram | ☐ Stress Test |
| ☐ Arthroscopy | ☐ Ultrasound | ☐ MRI | ☐ Urine Test |
| ☐ Biopsy | ☐ Echocardiogram | ☐ Pap smear | ☐ X - Ray |
| ☐ Blood Test | ☐ EEG | ☐ Pulmonary Function Test | ☐ _____ |
| ☐ Bone Scan | ☐ EKG | ☐ Spinal Tap | ☐ _____ |

## Medications & Allergies - Please check or list all medications or allergies:

**Non-Prescription:**

| | | |
|---|---|---|
| ☐ No Medications | ☐ Decongestants | ☐ Motrin |
| ☐ Advil/Alleve | ☐ Excedrin | ☐ Vitamins/minerals |
| ☐ Antihistamines | ☐ Herbal Supplements | ☐ Tylenol |
| ☐ Asprin | ☐ Ibuprophen/Naproxen | ☐ _____ |

**Prescription:** ☐ No Medications ☐ _____

**Allergies:** ☐ No Known Allergies To Date ☐ _____

## Functional Status/Activity Level:

**Current Functional Status:**

Difficulty with locomotion/movement Such as: ☐ Bed Mobility ☐ Transfers (such as bed to chair, from bed to commode/toilet

☐ Gait (Walking) ☐ on level surfaces ☐ on ramps ☐ on stairs ☐ on uneven surfaces

Difficulty with self care activities such as: ☐ Bathing ☐ Dressing ☐ Toileting

Difficulty with home management such as: ☐ Household Chores ☐ Shopping ☐ Driving/Trasportation ☐ Care of Dependents

Difficulty with community and work activities such as: ☐ Work ☐ School ☐ Recreation ☐ Sport ☐ Play Activity

**Prior Functional Status** **(Your status prior to the date of onset/injury):**

Prior to your current injury or condition, were you pain free without any difficulty with locomotion/movement, self care activities, home management, community and work activities..... ☐ Yes ☐ No

If No, Please Explain: _____

## Current Condition(s)/Chief Complaints:

**Nature of Onset/Injury:** ☐ Motor Vehicle Accident ☐ Fall ☐ Unknown Onset ☐ Work Related Injury ☐ Traumatic Event ☐ _____ ☐ Gradual Onset ☐ Ongoing/Chronic Condition

**Date of Onset:** _____

**Briefly Describe What Happened?** _____

**Chief Complaints or Problems?** _____

**Overall How Would You Describe the Intensity of your Symptoms?** ☐ Slight ☐ Minimal ☐ Moderate ☐ Severe ☐ Emergency

**Overall, How Frequent Are Your Symptoms?** ☐ Intermittent (off & on) ☐ Occasionally (sometimes) ☐ Constant (all the time)

**Have you ever had this problem(s) before?** ☐ Yes ☐ No **What did you do for the problem(s)?** _____

**Did the problem get better?** ☐ Yes ☐ No **How long did the problem(s) last?** _____

**What Makes Your Symptoms Worse?** _____

**What Makes Your Symptoms Better?** _____

**What is Your Goal For Physical Therapy?** _____

**Are You Seeing Anyone Else For Your Problem?** ☐ Yes ☐ No **If Yes, Please Check all that Apply.**

☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Neurologist ☐ Podiatrist
☐ Family Doctor ☐ Orthopedist ☐ Massage Therapist ☐ Rheumatologist ☐ _____