



# db Orthopedic Physical Therapy, PC

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

Leisure activities, including exercise routines: \_\_\_\_\_

Occupation, including activities that comprise your workday: \_\_\_\_\_

Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Are you on a work restriction from your doctor?  Yes  No    Are you latex sensitive?  Yes  No  
Do you smoke?  Yes  No    Do you have a pacemaker?  Yes  No  
FOR WOMEN: Are you currently pregnant or think you might be pregnant?  Yes  No  
ALLERGIES: List any medication(s) you are allergic to: \_\_\_\_\_

**Have you RECENTLY noted any of the following (check all that apply)?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> fatigue                                      | <input type="checkbox"/> numbness or tingling                 | <input type="checkbox"/> constipation        |
| <input type="checkbox"/> fever/chills/sweats                          | <input type="checkbox"/> muscle weakness                      | <input type="checkbox"/> diarrhea            |
| <input type="checkbox"/> nausea/vomiting                              | <input type="checkbox"/> dizziness/lightheadedness            | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> weight loss/gain                             | <input type="checkbox"/> heartburn/indigestion                | <input type="checkbox"/> fainting            |
| <input type="checkbox"/> difficulty maintaining balance while walking | <input type="checkbox"/> difficulty swallowing                | <input type="checkbox"/> cough               |
| <input type="checkbox"/> falls  | <input type="checkbox"/> changes in bowel or bladder function | <input type="checkbox"/> headaches           |

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> cancer                                 | <input type="checkbox"/> depression                       | <input type="checkbox"/> thyroid problems      |
| <input type="checkbox"/> heart problems                         | <input type="checkbox"/> lung problems                    | <input type="checkbox"/> diabetes              |
| <input type="checkbox"/> chest pain/angina                      | <input type="checkbox"/> tuberculosis                     | <input type="checkbox"/> osteoporosis          |
| <input type="checkbox"/> high blood pressure                    | <input type="checkbox"/> asthma                           | <input type="checkbox"/> multiple sclerosis    |
| <input type="checkbox"/> circulation problems                   | <input type="checkbox"/> rheumatoid arthritis             | <input type="checkbox"/> epilepsy              |
| <input type="checkbox"/> blood clots                            | <input type="checkbox"/> other arthritic condition        | <input type="checkbox"/> eye problem/infection |
| <input type="checkbox"/> stroke                                 | <input type="checkbox"/> bladder/urinary tract infection  | <input type="checkbox"/> ulcers                |
| <input type="checkbox"/> anemia                                 | <input type="checkbox"/> kidney problem/infection         | <input type="checkbox"/> liver problems        |
| <input type="checkbox"/> bone or joint infection                | <input type="checkbox"/> sexually transmitted disease/HIV | <input type="checkbox"/> hepatitis             |
| <input type="checkbox"/> chemical dependency (i.e., alcoholism) | <input type="checkbox"/> pelvic inflammatory disease      | <input type="checkbox"/> pneumonia             |

**Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?**

- |  |                                     |   |
|--|-------------------------------------|---|
| <input type="checkbox"/> cancer              | <input type="checkbox"/> diabetes   | <input type="checkbox"/> tuberculosis     |
| <input type="checkbox"/> heart problems      | <input type="checkbox"/> stroke     | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> depression | <input type="checkbox"/> blood clots      |

During the past month have you been feeling down, depressed or hopeless?  YES  NO  
During the past month have you been bothered by having little interest or pleasure in doing things?  YES  NO  
Is this something with which you would like help?  YES  YES, BUT NOT TODAY  NO

**Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):**

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

Have you ever taken steroid medications for any medical conditions?  YES  NO  
Have you ever taken blood thinning or anticoagulant medications for any medical conditions?  YES  NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

What date (roughly) did your present symptoms start? \_\_\_\_\_

What do you think caused your symptoms? \_\_\_\_\_

My symptoms are currently:  Getting Better  Getting Worse  Staying about the same

I should not do physical activities that might make my pain worse:  Disagree  Unsure  Agree

Treatment received so far for this problem (chiropractic, injections, etc) \_\_\_\_\_

Please list special tests performed for this problem (x-ray, MRI, labs, etc) \_\_\_\_\_

Have you ever had this problem before:  Yes  No When \_\_\_\_\_ Treatment rec'd \_\_\_\_\_

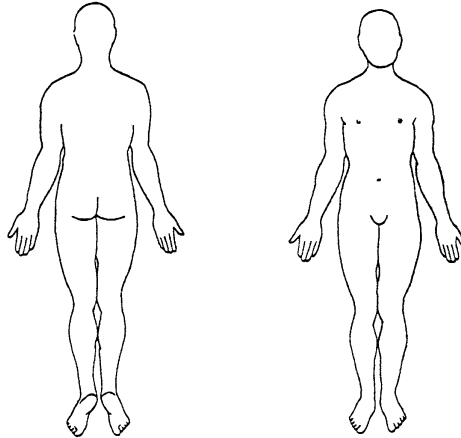
How long did it take for you to feel better? \_\_\_\_\_

**Body Chart:**

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

Describe pain in box

- ↓ Shooting/sharp pain
- Dull/aching pain
- ||| Numbness
- = Tingling



My symptoms currently:  Come and go  Are Constant  Are constant, but change with activity

**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Easing Factors:** Identify up to 3 important positions or activities that make your symptoms better:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**How are you currently able to sleep at night due to your symptoms?**

No problem sleeping  Difficulty falling asleep  Awakened by pain  Sleep only with medication

When are your symptoms worst?  Morning  Afternoon  Evening  Night  After exercise

When are your symptoms the best?  Morning  Afternoon  Evening  Night  After exercise

**Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:**

Your current level of pain while completing this survey: \_\_\_\_\_

The best your pain has been during the past 24 hours: \_\_\_\_\_

The worst your pain has been during the past 24 hours: \_\_\_\_\_