

# Seneca Physical Therapy Clinical Information Form

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Describe your symptoms \_\_\_\_\_

When did your symptoms first start? \_\_\_\_\_

Have you had treatment for this condition before?  Yes  No

How often do you experience your symptoms?

- Constantly (75-100% of the day)
- Frequently (50-75% of the day)
- Intermittently (25-50% of the day)
- Occasionally (0-25% of the day)

Please describe the words that best describe your symptoms.

- |                                |                                   |                                  |                                |                                    |
|--------------------------------|-----------------------------------|----------------------------------|--------------------------------|------------------------------------|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Shooting | <input type="checkbox"/> Burning | <input type="checkbox"/> Heavy | <input type="checkbox"/> Throbbing |
| <input type="checkbox"/> Ache  | <input type="checkbox"/> Tingling | <input type="checkbox"/> Dull    | <input type="checkbox"/> Tight | <input type="checkbox"/> Stabbing  |
| <input type="checkbox"/> Numb  | <input type="checkbox"/> Pulling  |                                  |                                |                                    |

Please rate your average pain in the last 24 hours

(No pain) 01    2    3    4    5    6    7    8    9    10 (Severe pain)

List any positions or activities that **increase** your symptoms

List any positions or activities that **decrease** your symptoms

Did you have any falls over the past year?  Yes  No

*If yes, how many falls?* \_\_\_\_\_

Did you have an injury as a result of the fall?  Yes  No

## Medical History

Age \_\_\_\_\_ Weight \_\_\_\_\_ lbs

Check **ALL** of the conditions that apply to you:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Multiple Sclerosis  | <input type="checkbox"/> Macular Degeneration        |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Hearing Impairment          |
| <input type="checkbox"/> Osteoporosis         | <input type="checkbox"/> Stroke              | <input type="checkbox"/> Asthma                      |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Allergies           | <input type="checkbox"/> Hepatitis/HIV/AIDS          |
| <input type="checkbox"/> COPD                 | <input type="checkbox"/> Angina              | <input type="checkbox"/> Peripheral Vascular Disease |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Incontinence        | <input type="checkbox"/> High Blood Pressure         |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Constipation        | <input type="checkbox"/> Kidney/Bladder/Prostate     |
| <input type="checkbox"/> Heart Attack         | <input type="checkbox"/> Cataracts/Glaucoma  | <input type="checkbox"/> Gastrointestinal Disease    |
| <input type="checkbox"/> Prosthesis           | <input type="checkbox"/> Depression          | <input type="checkbox"/> Congestive Heart Failure    |

Other \_\_\_\_\_

Have any immediate family members been treated for any of the above conditions?

Yes  No

*If yes, please specify*

Do you wear a pacemaker?  Yes  No

Are you currently pregnant?  Yes  No

Please list past surgical history with approximate dates:

Please list any prescription and over the counter medications:

What tests have you had for your symptoms? *(Please provide date. If not tested, leave blank)*

- |  |                                      |  |
|--|--------------------------------------|--|
| <input type="checkbox"/> X-rays _____    | <input type="checkbox"/> MRI _____   | <input type="checkbox"/> CT Scan _____ |
| <input type="checkbox"/> DEXA Scan _____ | <input type="checkbox"/> Other _____ |  |

## Social History

How many times a week do you complete at least 20 minutes of exercise?

3 or more  1-2  Seldom/Never

Please list your exercise/recreational activities

Occupation \_\_\_\_\_

What is your employment status?

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Employed (full duty) | <input type="checkbox"/> Employed (restricted duty) | <input type="checkbox"/> Disability |
| <input type="checkbox"/> Retired              | <input type="checkbox"/> Student                    | <input type="checkbox"/> Unemployed |