

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)

What words best describe your symptoms?

- Sharp Shooting Burning Heavy Throbbing Ache
 Tingling Dull Tight Stabbing Numb Pulling

Please rate your pain in the last 24 hours

(No pain) 0 1 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? _____*
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"/> Congestive Heart Failure | <input type="checkbox"/> Hepatitis/HIV/AIDS |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Allergies | <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"/> Kidney/Bladder/Prostate |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cataracts/Glaucoma | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Constipation | <input type="checkbox"/> Gastrointestinal Disease | <input type="checkbox"/> 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)*

- X-rays _____ MRI _____ CT Scan _____
 DEXA Scan _____ 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?

- Employed (full duty) Employed (restricted duty) Disability Retired Student Unemployed