USF HEALTH

SCHOOL OF PHYSICAL THERAPY & REHABILITATION SCIENCES
MORSANI COLLEGE OF MEDICINE

Name: _____ Date of Birth: _____ MR#: _____

What is the problem that brings you to physical therapy?

_____

_____

What are your goals for physical therapy? _____

_____

_____

_____

Do you take prescription medications? ____ Yes ____No

If yes, please list: _____ _____ _____

_____ _____ _____

_____ _____ _____

Do you take any non-prescription medications: _____ Yes _____ No

_____ Advil/Aleve _____ Antacids _____ Ibuprofen/Naproxen _____ Other: _____

_____ Antihistamines _____ Aspirin _____ Decongestants _____

_____ Herbal Supplements _____ Tylenol _____ Sleeping Aids _____

Do you have any adverse reactions to medication? _____ Yes _____No

If yes, please list and describe reaction: _____

Within the past year have you had any of the following symptoms? (Check all that apply)

____ Chest pain ____ Heart palpitations ____Cough _____ Pain at night

____ Hoarseness ____ Shortness of breath ____ Dizziness/blackouts _____ Headaches

____ Loss of balance ____ Difficulty walking ____Coordination problems _____ Hearing Problems

____ Sleeplessness ____ Loss of appetite ____ Weakness in arms/legs _____ Vision Problems

____Nausea/Vomiting ____ Difficulty swallowing ____ Bowel problems Other: _____

____Weight loss/gain ____ Urinary problems ____ Fever/Chills/Sweats _____

Please check if you have ever had:

____ Arthritis ____ Lung problems _____ Cancer

____ Broken bones/Fractures ____ Stroke _____ Kidney Problems

____ Osteoporosis ____ Diabetes/High blood sugar _____ Ulcers/Stomach Problems

____ Blood disorders ____ Hypoglycemia _____ Depression

____ Circulation/Vascular problems ____ Head injury _____ Anxiety

____ Heart problems ____ Multiple Sclerosis _____ Repeated Infections

____ High blood pressure ____ Muscular Dystrophy _____ Skin Disease

____ Parkinson disease ____ Seizures/epilepsy _____ Infectious Disease (TB, Hepatitis)

____ Developmental/growth problem ____ Thyroid problem _____ Other:_____

Are you pregnant or think you might be? _____ Yes _____ No

Do you have any known allergies? _____ Yes _____ No Please List: _____

Have you ever had surgery? ____ Yes____ No

If yes, please describe and include dates: _____

_____

Are you: _____Right Handed _____Left Handed _____Ambidextrous

Education: Please indicate the highest grade completed (circle one)

1 2 3 4 5 6 7 8 9 10 11 12 college/technical school Graduate school/advanced degree

Are there any customs or religious beliefs or wishes that might affect your care? If yes, please describe:

_____

Please rate your overall health: ___Excellent ___ Good ___ Fair ___ Poor Date of last physical: _____

Do you currently smoke? _____Yes _____ No Did you smoke in the past? ____Yes _____No

Do you drink alcohol? _____Yes _____ No If yes, how often? _____ Seldom _____ Occasionally

_____ Weekly _____ Daily

Do you exercise beyond normal daily activities and chores? _____Yes _____No

Please describe: _____

Are you experiencing a need for the following social services?

Financial:

Do have enough money to buy the food you need? Yes No

Do have enough money to buy the medical care/medications you need? Yes No

In-Home Care:

Do you need someone to stay with you at **home?** Yes No

Socialization:

Do any physical problem(s) stand in the way of your doing things? Yes No

Do you participate in activities outside the home? Yes No

Mental Health:

How would you describe your satisfaction with your life? _____

Compared to a year ago how is your attitude toward life? _____

Do you currently receive?

Home health services Yes No

Community services (meals on wheels, lifeline, etc.) Yes No If yes, what services? _____

Mental health services Yes No

Is this service(s) meeting your needs? Yes No

If no, what needs are unmet? _____

How did you hear about the USF Physical Therapy Center?

_____ Television _____ Radio _____ Newspaper _____ Personal Health Insurance Plan

_____ Friend _____ Physician _____ Staff/Faculty Other: _____

Please use this space for any additional information you would like us to know.

_____

_____

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist.

If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments, this allows us to utilize your appointment time for other patients.

We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

Person completing form: _____ **Date:** _____