



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: _____