IMPACT PHYSICAL THERAPY

Name: _____ Date of Birth: _____

Height: _____ Hand Dominance: ☐ Right ☐ Left ☐ Ambidextrous

Weight: _____

Primary Care Doctor: _____ Referring Doctor: _____

Briefly describe what brought you in today: _____

_____

_____

Past Medical History

General	Yes	No
Changes in appetite	☐	☐
Weight gain/lost	☐	☐
Excessive thirst	☐	☐
Fatigue	☐	☐
Frequent infections	☐	☐
Fevers	☐	☐
Nausea/ Vomiting	☐	☐
Night Sweats	☐	☐
Loss of balance/falls	☐	☐
Liver Disease	☐	☐
Hernia	☐	☐
Hypo- or hyper- thyroid	☐	☐
Open wounds/skin problems	☐	☐
Arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Osteoporosis/Osteopenia	☐	☐
Sleep apnea	☐	☐
Diabetes Type 1 or 2	☐	☐

Psychiatric	Yes	No
Anxiety	☐	☐
Depression	☐	☐
Bipolar Disorder	☐	☐
Schizophrenia	☐	☐

Neurologic	Yes	No
Memory loss	☐	☐
Head Injury/ Concussion	☐	☐
Difficulty swallowing	☐	☐
Dizziness/Lightheadedness	☐	☐
Headaches / Migraines	☐	☐
Tremor	☐	☐
Neuropathy	☐	☐
Alzheimer's	☐	☐
Dementia	☐	☐
Multiple Sclerosis	☐	☐
Myasthenia gravis	☐	☐
Parkinson's Disease	☐	☐
Seizures/ epilepsy	☐	☐
Stroke or TIA	☐	☐
Aneurysm	☐	☐

Cardiovascular	Yes	No
Blood Disorder	☐	☐
Heart Attack	☐	☐
Heart Failure	☐	☐
High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Pacemaker/ Defibrillator	☐	☐
Circulation problems	☐	☐

Respiratory	Yes	No
Asthma	☐	☐
COPD	☐	☐
Emphysema	☐	☐
Shortness of Breath	☐	☐

GI/GU	Yes	No
Abdominal/Pelvic Pain	☐	☐
Painful urination	☐	☐
Constipation/ Diarrhea	☐	☐
Difficult / Frequent urination	☐	☐
Leakage of urine/ feces	☐	☐
Ulcers	☐	☐
Irregular periods	☐	☐
Reflux	☐	☐
Barrett's Esophagus	☐	☐
Endometriosis	☐	☐
Kidney stones	☐	☐
Diverticulitis/ Diverticulosis	☐	☐
Kidney Disease/ Failure	☐	☐

Ophthalmologic	Yes	No
Glaucoma	☐	☐
Macular Degeneration	☐	☐
Cataracts	☐	☐

Cancer	Yes	No

Please List: _____

OTHER ILLNESS OR CONDITIONS NOT LISTED: _____

_____

_____

TESTS & TREATMENTS (in the past 1 year)

- ☐ x-rays
- ☐ EKG
- ☐ Biopsy
- ☐ Prednisone
- ☐ Radiation
- ☐ MRI
- ☐ Blood test
- ☐ Mammogram
- ☐ Injections
- ☐ Botox Injections
- ☐ CT Scan
- ☐ Stress test
- ☐ Bone scan
- ☐ Bone Density Test
- ☐ EMG
- ☐ Physical Therapy
- ☐ Vestibular Test
- ☐ Acupuncture
- ☐ Chiropractic
- ☐ Other (please specify)

OTHER TEST or TREATMENTS NOT LISTED: _____

_____

_____

SURGERIES (All)

Type	Year

HOSPITALIZATIONS (within past 6 months)

Name	Date

MEDICATIONS: (Please list ALL of your current medications: prescribed, over the counter, supplements)

Name	Dose	Year

ALLERGIES ☐ Yes ☐ NO LATEX ALLERGY ☐ Yes ☐ NO

If yes, please list _____

CURRENTLY PREGNANT OR TRYING TO GET PREGNANT? ☐ Yes ☐ NO ☐ N/A

SOCIAL HISTORY: (Please answer as accurately as possible)

I Live (with)	My home is:	My home has: (check all that apply)		
☐ alone ☐ a spouse ☐ children ☐ a relative ☐ a friend	☐ one level ☐ multiple levels	☐ stairs at the entrance	☐ handrail is on the right when ascending ☐ handrail is on the left when ascending ☐ no handrail	
	My bedroom is: ☐ on the 1st floor ☐ on the 2nd floor ☐ I sleep in a recliner	☐ stairs in the home	☐ handrail is on the right when ascending ☐ handrail is on the left when ascending ☐ no handrail	
		☐ Assisted devices in the home ☐ cane ☐ a reacher	☐ grab bars ☐ raised toilet seat ☐ commode	☐ walker ☐ wheelchair ☐ crutches