**Aspen Grove Physical Therapy LLC**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_\_\_\_\_\_

Occupation/Interests\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your goals for therapy?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had physical or occupational therapy in the last year? Please indicate what area was treated:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you fallen in the past year? \_\_\_\_\_ How many times?\_\_\_\_\_\_\_\_\_\_ Were you injured?\_\_\_\_\_

Are you receiving home health care ?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate previous surgeries\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you have had any testing for this condition? (MRI, X-ray, Urodynamics)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list any allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle the worst and best your pain has been over this past week:

0\_\_\_\_\_\_\_\_\_\_\_\_\_3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_5\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_7\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_10

None moderate severe

Do you have any of the following:

|  |  |  |
| --- | --- | --- |
| Headaches | Pacemaker | Mental health concerns |
| Vision or hearing problems | Gout | Cancer |
| Lung conditions or Asthma | Osteoporosis/osteopenia | Frequent falls/poor balance |
| Heart Attack | Dizziness/fainting | Multiple sclerosis |
| Heart condition/surgery | Difficulty with blood clots | Stroke |
| Chest pain | Low/high blood pressure | Diabetes |
| Hiatal hernia | Nausea/vomiting | Arthritis |
| Pregnancy | Fibromyalgia |  |

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_