
**Are you currently participating in any other therapy (PT/OT, Pulmonary, etc.) or are you receiving any Home Health Care, nursing, or do other health care service agencies come to your home to deliver any services at this time?**

**Yes OR No**

**<u>If yes, please let us know before proceeding.</u>**

Name : _____

(last) (first) (middle initial)

Date of birth: _____ Height: _____ Weight: _____

Home Phone: _____ Cell Phone: _____ Email:_____

Address: _____

**Job Information**

Occupation: Still Working?

**Emergency Contact Information**

Name: _____ Phone: _____ Relation: _____

1) When did your problems begin? _____
2) Briefly describe what occurred: _____
3) PAIN SCALE - **NOW**: 0 1 2 3 4 5 6 7 8 9 10
4) PAIN SCALE – **AT BEST**: 0 1 2 3 4 5 6 7 8 9 10
5) PAIN SCALE – **AT WORST**: 0 1 2 3 4 5 6 7 8 9 10
6) When do you have your symptoms or pain? (*circle one*)
    a. Constant
    b. Intermittent (come and go)
    c. Only at night
    d. Other times
7) How long do your symptoms last? _____
8) When are your symptoms or pain worse? _____
9) Do your symptoms or pain move from one place to another? **Yes / No** Where does it travel?
10) What makes your symptoms or pain worse?

11) What makes your symptoms or pain better or ease off?

12) Check the words that describe your symptoms or pain:

| | | | | |
|---|---|---|---|---|
| Aching | Cramping | Hot | Pins and needles | Tender |
| Burning | Deep | Itching | Sharp | Throbbing |
| Cold | Dull | Numbness | Shooting | Tingling |
| Constant | Heavy | Penetrating | Stabbing | Weak |

13) Balance issues:

a. Do you have any difficulty with your gait or maintaining your balance? **Y / N**

b. Can you stand from a sitting position without using your hands? **Y / N**

14) Do your symptoms or pain interrupt your sleep? **Y / N**

15) Do you wake up at night or in the morning with the pain? **Y / N**

16) What do your symptoms or pain prevent you from doing?

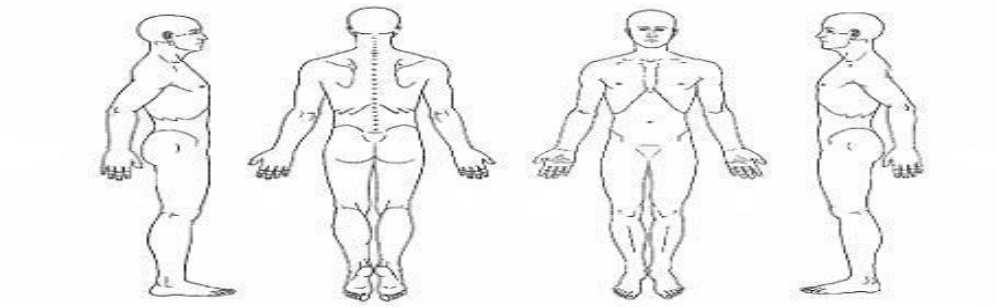
14) What is your primary goal for therapy?

15) What do you feel caused your diagnosis (Circle one)?

a. Diabetes
b. Idiopathic (Unknown)
c. ChemoRx induced
d. Toxic agent
e. Other _____

16) Have you ever seen a neurologist? If yes when? _____

**Where are your symptoms?**



**Medical History**

| Condition | Yes | No | Year | Condition | Yes | No | Year | Condition | Yes | No | Year |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Anemia | | | | GI Ulcers | | | | Neuropathy | | | |
| Angina | | | | Gout | | | | Parkinson's Disease | | | |
| Arthritis | | | | Hard of Hearing | | | | Pulmonary Embolism | | | |
| Asthma | | | | Heart Attack | | | | Weight Loss/Gain | | | |
| Atrial Fibrillation | | | | Heart Disease | | | | Restless Leg | | | |
| Auto Immune Disorder | | | | Heart Murmur | | | | Raynaud's Disease | | | |
| Back Pain | | | | Hepatitis | | | | Rheumatic Fever | | | |
| Blood Clots | | | | Hiatal Hernia | | | | Seasonal Allergies | | | |
| Cancer | | | | High Blood Pressure | | | | Sleep Apnea | | | |
| Circulation Issues | | | | High Cholesterol | | | | STD's | | | |
| COPD | | | | Infectious Disease | | | | Stroke (CVA) | | | |
| Depression | | | | Kidney Disease | | | | Thyroid Disease | | | |
| Diabetes | | | | Liver Disease | | | | TIA | | | |
| DVT | | | | Lung Disease | | | | Tuberculosis | | | |
| Epilepsy | | | | Migraines | | | | Do you use CPAP? | | | |
| Fibromyalgia | | | | Neck Pain | | | | Do you Smoke | | | |

- Who is your primary physician? _____
- Surgeries? (*Type and date*) _____
- Medications: (Medication Name, Dosage, Tab/Cap, # of times per day)

  _____

  _____
- Other significant medical history: _____

Do you have trouble with any of the following? Please check all that apply:

| | | |
|---|---|---|
| Lying Flat | Walking short distance | Pulling |
| Rolling Over | Walking long distance | Reaching |
| Moving lying to sitting | Walking outdoors | Grasping |
| Sitting | Climbing stairs | Lifting |
| Squatting | Hopping | Carrying |
| Bending/Stooping | Jumping | Kneeling |
| Balancing | Running | Pushing |
| Sleeping | Driving | Standing |

How did you learn about Complete Rehab?

☐Doctor _____ ☐Family/Friend _____ ☐Website_____

☐Newspaper_____ ☐Magazine_____ ☐Radio_____

☐Other_____