Name:
DOB:
DATE:

Fairfax Family Physical Therapy, P.C.
Patient History Information

Age: _____ **Sex:** ☐ Male ☐ Female

Social History

Do you have support at home? Ie: spouse, partner, parents, etc. Describe:_____
Who referred you to the Therapist: _____
Do you foresee any problems in getting your treatments (going on vacation, transportation, finances Etc…)?_____
Do you wish to be contacted via email? **Yes, No**. Email address:_____
Have you received physical therapy, occupational therapy or chiropractic services in the past year? **Yes No**
Are you receiving or have received any home health services or Cardiac or Pulmonary Rehabilitation this past year? **Yes No**

Living Environment

Does your home have?

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Elevator ☐ Uneven terrain
☐ Assistive devices (eg, bathroom): _____☐ Any Obstacles: _____
Do you have any medical equipment at home (DME) walker, braces, etc: _____

General Health Status

Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you had any major life changes during the past year? (eg, new baby, job change, death in the family) ☐ Yes ☐ No
Describe:_____

MEDICARE PATIENTS –

Have you fallen in the past year ☐No ☐ Yes if yes how many times/describe_____
What is your weight _____ Height _____ (***For Staff BMI calculation_____, Verified by_____)***

Social Health Habits

Exercise: Do you exercise beyond normal daily activities and chores? ☐ No ☐ Yes, Describe the exercise:
_____
Do you Smoke? ☐ No ☐ Yes How Much_____Do you drink ☐ No ☐ Yes How Much _____

Medical/Surgical History Please check all that apply to you:

☐Alcohol/Drug Dependence	☐Recent Fever	☐Dizziness/fainting
☐ Arthritis	☐ Broken bones/fractures	☐ Osteoporosis
☐ Blood disorders	☐ Circulation/vascular problems	☐ Heart problems
☐ High blood pressure	☐ Lung problems	☐ Stroke
☐ Diabetes/high blood sugar	☐ Low blood sugar/hypoglycemia	☐ Head injury
☐ Multiple sclerosis	☐ Muscular dystrophy	☐ Parkinson disease
☐ Seizures/epilepsy	☐ Allergies	☐ Thyroid problems
☐ Cancer	☐ Infectious disease (tuberculosis, hepatitis)	☐ Kidney Problems
☐ Repeated infections	☐ Ulcers/stomach problems	☐ Skin disease/Cellulitis
☐ Depression	☐ Developmental or growth problems	☐ High Cholesterol
☐ Impaired Vision	☐ Abnormal Weight Gain	☐pain at night
☐Currently Pregnant #weeks	☐Pain unrelieved by position or rest	☐Other: _____

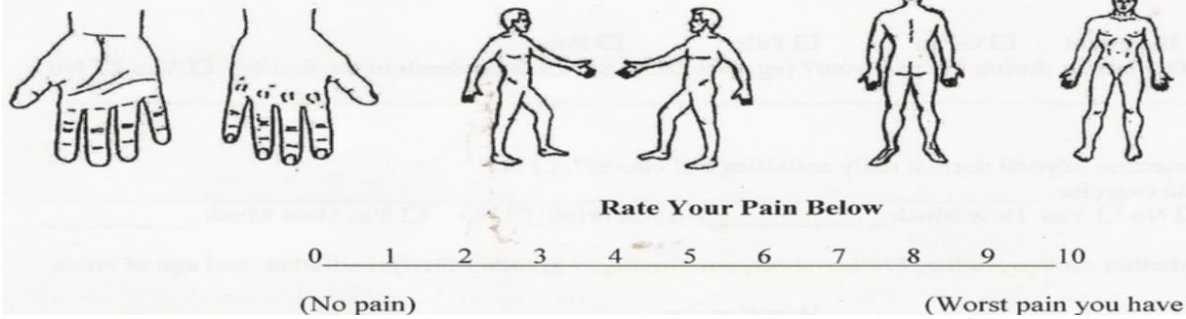
Have you ever had surgery? ☐ Yes ☐ No
If yes, please describe and include the dates:
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____

Over

Patient's Name: _____ Date: _____
Employment/Work /Play: Occupation: _____
Describe job duties_____ Are you currently: Working outside of the home ☐full-time ☐ part time Working from home ☐full-time ☐part time
☐ Unemployed ☐Homemaker ☐ Retired ☐ Student Hobbies/Sports _____
☐Out of work due to injury
☐On work restrictions (please describe)_____

Current Condition(s)/Chief Complaint(s)
Describe the problem(s) for which you seek physical therapy and how it began: _____
_____
When did the problem(s) begin (date)? _____/_____/_____
Is this related to Work_____, Auto, _____, other _____
Have you ever had the pain before? ☐ No☐ Yes ☐ what did you do for the problem(s)include who you saw and what type of treatment was provided._____
How often are your symptoms present: consider a percentage of the whole day
☐Constant (76-100%) ☐ Frequently (51%-75%) ☐ Occasionally (26-60%) ☐Intermittently (0-25%)
Describe the nature of your pain: ☐ sharp ☐dull ache ☐ numb ☐shooting ☐burning ☐tingling
How is your condition changing? ☐Getting better ☐ not changing ☐ getting worse
In the past week how much has your pain interfered with your daily activities:
0 1 2 3 4 5 6 7 8 9 10
(no interference) (Unable to carry on any activities)

Use the pictures to show the location of your pain/problem Note any areas of numbness or tingling with ∘ ∘∘ ∘



Rate Your Pain Below

0 1 2 3 4 5 6 7 8 9 10

(No pain) (Worst pain you have ever had)

Is Your Problem(s) affecting /giving difficulty with:
☐ Gait (walking) ☐ On level ☐ On ramps ☐ On stairs ☐ On uneven terrain
☐ Self-care (such as bathing, dressing, eating, toileting) ☐ Bed mobility ☐Sleeping
☐Household chores ☐Shopping ☐Driving/transportation ☐ Care of dependents
☐ Recreation or play activity ☐Work ☐School
How are you taking care of the problem(s) now? _____
What makes the problem(s) better? _____
What makes the problem (s) worse? _____
Have you had therapy before ☐Yes ☐No What are your goals for therapy? _____

Are you seeing anyone else for the problem(s)? (Check all that apply)
☐ Acupuncturist ☐ Cardiologist ☐ Chiropractor ☐ Dentist
☐ Family Practitioner ☐ Internist ☐ Massage Therapist ☐ Neurologist
☐ Obstetrician/Gynecologist ☐ Occupational Therapist ☐ Orthopedist ☐ Osteopath
☐ Pediatrician ☐ Podiatrist ☐ Primary Care Physician ☐ Rheumatologist
☐ Other: _____

Medications
Do you take any prescription medications? ☐ No ☐ Yes If yes, please list all medications (include Diuretics, Steroids and Hormone Replacement Therapy) include dosage, frequency and route:
_____
Do you take any nonprescription medications? (Check all that apply)
☐ Advil/Aleve ☐ Antacids ☐ Vitamins ☐ Ibuprofen/Naproxen ☐ Antihistamines
☐ Aspirin ☐ Decongestants ☐ Herbal supplements ☐ Tylenol
☐ Other: _____

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