New Client Information Sheet

Name: _____ **Date of Birth:**_____ **Height:** _____ **Weight:**_____

Current Areas of Concern: _____

_____

_____

Date(s) of Onset: _____

Do you have a history of any of the following? (Please check all that apply)

	Yes
Asthma/Breathing Difficulties	
Bowel/Bladder Abnormalities	
Cancer	
Diabetes	
Headaches	
Heart Disease	
Hernia	
High Blood Pressure	
Incontinence/Urinary Abnormalities	
Kidney Problems	
Liver/Gallbladder Problems	
Pacemaker	

	Yes
Pregnancy	
Metal Implants	
Multiple Sclerosis	
Osteoporosis	
Recent Fractures (< 5 years ago)	
Rheumatoid Arthritis	
Ringing in the ears	
Seizures	
Smoking	
Stroke/CVA	
Surgeries	
Other	

If you have listed yes to any of the above, please explain more below:

Have you recently noticed? (please check all that apply)

	Yes
Unexplained Weight Gain/Loss	
Nausea/Vomiting	
Dizziness/Fainting	
Fatigue	
Weakness	
Vision Changes	

	Yes
Fevers/Chills/Sweats	
Numbness/Tingling	
Chest Pain/Angina	
Shortness of Breath	
Night Pain	
Difficulty with Speech/Swallowing	

Physical Therapist's Signature: _____, PT Date:_____

New Client Information Sheet

Please list any other relevant medical history you feel we should know (i.e. Surgeries, hospitalizations):

Have you received PT for any of the items listed above? ☐ Yes ☐No If yes, please provide dates of service

Have you received any Diagnostic Imaging in the last 3 years for your current condition?

☐ Xrays ☐ MRI ☐ CT Scan ☐Ultrasound ☐ Bone Density Scan ☐ Other _____

Results:_____

Are you currently in pain? ☐Yes ☐No Location(s):_____

How would you describe your primary pain (circle)?

Sharp Shooting Dull/Ache Deep Superficial Burning Constant Intermittent

Please rate your primary pain using a 0-10 scale (0 = no pain, 10 = the worst pain you can imagine)

CURRENT pain _____/10 LEAST pain since onset _____/10 WORST pain since onset_____/10

What makes your pain better?_____

What makes your pain worse?_____

Do you take your blood pressure regularly? ☐ Yes ☐ No What was your most recent reading? _____

Have you fallen in the last 12 months? ☐ Yes ☐ No If Yes, how many falls in the past year?_____

Reason for the fall: _____ Did it result in an injury? ☐ Yes ☐ No

Home Environment:

Do you live alone? ☐Yes ☐No If no, who lives with you?_____

Do you have stairs in or outside your house? ☐Yes ☐No If Yes, how many? _____

Do you have railings? ☐ Yes ☐ No Do you have grab bars? ☐ Yes ☐ No Where?_____

Do you have carpet or rugs? ☐ Yes ☐No Do you have any pets? ☐ Yes ☐No

Do you use any medical equipment (examples: cane, walker, shower chair)? ☐ Yes ☐ No. If yes, please list

Physical Therapist's Signature: _____, PT Date:_____

New Client Information Sheet

Personal History

Are you currently working? ☐Yes ☐ *Full-time* ☐*Part-time* ☐No

Does your condition limit your ability to work? ☐Yes ☐ No

If Yes, please explain _____

_____

Daily Activities

Do you have difficulty completing any of the below activities?

	Yes
Personal Care	
Showering/Bathing	
Dressing	
Toileting	
Grooming (ie. Brushing teeth/hair)	
Community Activities	
Grocery Shopping	
Driving **less than** 15 min	
Driving **more than** 15 min	
Recreational Activities	

	Yes
Household Activities	
Rising from chair or sitting down	
Walking from room to room	
Ambulating stairs	
Getting in/out of bed	
Fixing snack/getting drink of water	
Fixing a meal (lunch/dinner)	
Light household chores (ie. light cleaning/laundry)	
Heavier household chores (ie. gardening)	

Please list any other activities you have difficulty completing:

How would you rate your current health? ☐ **Poor** ☐ **Fair** ☐ **Good** ☐ **Very Good** ☐ **Excellent**

Any other information you would like the therapist to know: _____

_____

Emergency Contact _____ **Phone Number:** _____

Physical Therapist's Signature: _____, PT Date:_____

New Client Information Sheet

Relationship to Patient _____

Medication List: Please list your current medications below *(including vitamins and herbs)*

Medication Name	Frequency/ **Dosage** /Route of Admin

Physical Therapist's Signature: _____, PT Date:_____