FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

Chart #:_____

PATIENT INFORMATION

Date: _____

Name: _____ Last 4 SSN: _____ DOB: _____ Cell Phone: _____

Address: _____City/State: _____Zip: _____ Home Phone: _____

Email: _____ Employer: _____Work Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Date of Onset/Injury: _____ Diagnosis: _____

How Did You Hear About Us? Please check all that apply

My doctor referred me:☐

Another health professional referred me:☐

A friend referred me (name of friend so we can send a thank you card if possible):_____

Web search:☐

Yelp or Google review:☐

Social Media (check one): ☐Facebook ☐Twitter ☐Instagram ☐Nextdoor

Other: _____

Referring M.D. (If Applicable)

Name: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____Zip: _____

Next MD Appointment: _____

_____ **[Office use only]**_____

Insurance: Medicare___ Self Pay___ **Therapist:_____**

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PATIENT CURRENT HISTORY

Describe the current problem that brought you here:

_____

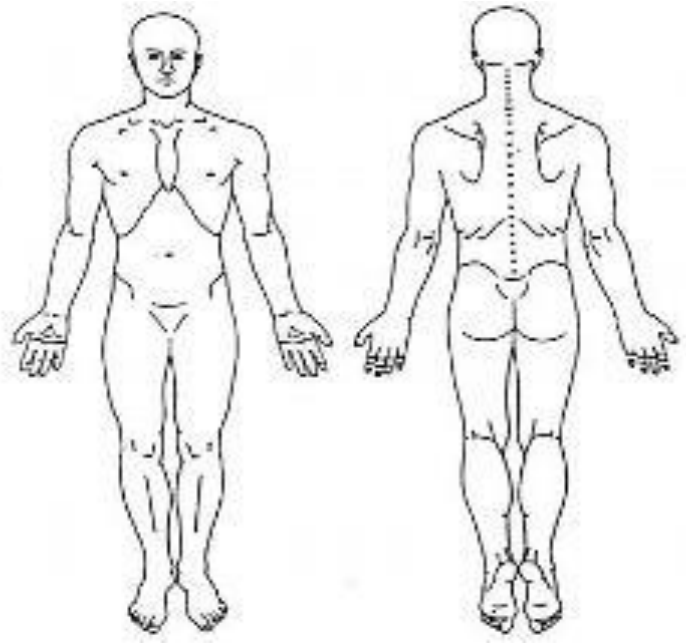
_____

When did your problem first begin? _____weeks ago, or _____months ago, or _____years ago

Since that time is it: staying the _____same _____ getting worse _____ getting better

Why or how might the problem have occurred?

_____



Circle where your symptoms are located and nature of the symptoms (i.e. dull, sharp, tingling, burning, numbness, weakness):_____

_____

On a scale of 0-10, what are your symptoms today? ____/10 When they are at their worst? ____/10

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Activities that cause or aggravate your symptoms: Check or circle all that apply.

- ☐ Sitting greater than _____minutes
- ☐ Walking greater than _____minutes
- ☐ Standing greater than _____minutes
- ☐ Changing positions (ie.- sit to stand)
- ☐ Lying on your side
- ☐ Stairs (going up or down)
- ☐ Lifting weight overhead
- ☐ Moving arm overhead/ out to side
- ☐ Light activity (light housework)
- ☐ With cough/ sneeze/ straining
- ☐ With laughing/ yelling
- ☐ With lifting/ bending
- ☐ With nervousness/ anxiety
- ☐ Lying on your stomach or back
- ☐ Running in straight line, jumping or pivoting
- ☐ Pushing/pulling on an object
- ☐ Moving arm behind your back
- ☐ Vigorous activity/ exercise

☐ Other, please list:

_____

_____

Activities that alleviate or lessen your symptoms. Check or circle all that apply

- ☐ Lying on your back
- ☐ Sitting upright with support
- ☐ Reclining
- ☐ Changing position frequently
- ☐ Ice
- ☐ Rest
- ☐ Lying on your stomach or back
- ☐ Lying on your back, knees bent
- ☐ Standing
- ☐ Exercising
- ☐ Heat
- ☐ Walking

☐ Other, please list:

_____

_____

Describe previous treatments/ exercises (including physical therapy, massage, chiropractic, ect.)

_____

_____

_____

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How has your lifestyle/ quality of life been altered/ changed because of this problem?
Social activities (exclude physical activities), specify_____
_____
Physical activity, specify_____
Work, specify _____

Other _____

What are your treatment goals/ concerns? _____
_____

One month prior to the onset of your current episode, and since that time, have you had:

Y/ N	Fever/ chills	Y/ N	Malaise (unexplained tiredness)
Y/ N	Unexplained weight loss	Y/ N	Unexplained muscle weakness
Y/ N	Dizziness or fainting	Y/ N	Night pain/ sweats
Y/ N	Change in bowel or bladder function	Y/ N	Bilateral numbness/ tingling
Y/ N	Numbness/ tingling to pelvic area	Y/ N	Changes in sexual function

Other please list: _____
_____

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HEALTH HISTORY

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Arrhythmias	Y/ N	Y/ N	Asthma	Y/ N	Y/ N
Mitral valve prolapse	Y/ N	Y/ N	COPD	Y/ N	Y/ N
Pacemaker	Y/ N	Y/ N	Chronic bronchitis	Y/ N	Y/ N
Murmur	Y/ N	Y/ N	Congestive heart failure	Y/ N	Y/ N
Heart attack	Y/ N	Y/ N	Episodes of fainting/ blacking out	Y/ N	Y/ N
Angina	Y/ N	Y/ N	Aortic aneurysm	Y/ N	Y/ N
Hypertension	Y/ N	Y/ N	Deep vein thrombosis (DVT)	Y/ N	Y/ N
Hypotension	Y/ N	Y/ N	Raynaud's disease/ phenomenon	Y/ N	Y/ N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you, or (they) have:

	Self	Family		Self	Family
Stroke	Y/ N	Y/ N	Migraines	Y/ N	Y/ N
Multiple Sclerosis	Y/ N	Y/ N	Unusual or frequent headaches	Y/ N	Y/ N
Polio	Y/ N	Y/ N	Bell's Palsy	Y/ N	Y/ N
Aneurysm	Y/ N	Y/ N	Shingles	Y/ N	Y/ N
Peripheral neuropathy	Y/ N	Y/ N	Seizures	Y/ N	Y/ N
Concussion	Y/ N	Y/ N	Parkinson's Disease	Y/ N	Y/ N
Head trauma	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Liver problems	Y/ N	Y/ N	Stomach ulcers	Y/ N	Y/ N
Ulcerative colitis	Y/ N	Y/ N	Hemorrhoids	Y/ N	Y/ N
Irritable bowel syndrome	Y/ N	Y/ N	Gallstones	Y/ N	Y/ N
Esophageal reflux	Y/ N	Y/ N	Constipation	Y/ N	Y/ N
Anorexia	Y/ N	Y/ N	Bulimia	Y/ N	Y/ N

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If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Diabetes	Y/ N	Y/ N	Addison's Disease	Y/ N	Y/ N
Hypothyroidism	Y/ N	Y/ N	Cushing's Syndrome	Y/ N	Y/ N
Hyperthyroidism	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Sexually transmitted disease	Y/ N	Y/ N	Urinary incontinence	Y/ N	Y/ N
Sexual dysfunction	Y/ N	Y/ N	Pelvic pain	Y/ N	Y/ N
Sexual abuse	Y/ N	Y/ N	Hysterectomy	Y/ N	Y/N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Osteoporosis	Y/ N	Y/ N	Hip dysplasia	Y/ N	Y/ N
Osteopenia	Y/ N	Y/ N	Scoliosis	Y/ N	Y/ N
Fibromyalgia	Y/ N	Y/ N	Flat feet	Y/ N	Y/ N
Hernia	Y/ N	Y/ N	High arches	Y/ N	Y/ N
Rheumatoid Arthritis	Y/ N	Y/ N	Osteoarthritis	Y/ N	Y/ N
Fractures	Y/ N	Y/ N	Ankylosing Spondylitis	Y/ N	Y/ N

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

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Have you, or any immediate family member, ever been told you (they) have:

	Self	Family		Self	Family
Physical abuse	Y/ N	Y/ N	Anxiety	Y/ N	Y/ N
Verbal abuse	Y/ N	Y/ N	Bi-polar disorder	Y/ N	Y/ N
Depression	Y/ N	Y/ N			

If yes to self-history, please list date of onset or if problem is ongoing

_____

_____

_____

PRESCRIPTION MEDICATIONS (Please list, or attach a copy, of current medications)

Dose	Date or Year Started	Reason for Medication

Over the Counter Medications, Vitamins, or Supplements (Please list, or attach a copy, of current medications)

Dose	Date or Year Started	Reason for Medication

Please List All Surgeries/ Overnight Hospitalization and Reason Why

Date and type of surgery	Reason

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GENERAL HEALTH

Do you smoke? **Y/N___** If yes, how many cigarettes or packs per day _____/day
Do you use chewing tobacco? **Y/N___**
Do you drink an alcoholic beverage? **Y/N___** If yes, how many glasses _____/day or _____/ week
How would you describe your general health? **Excellent Good Average Fair Poor _____**
What is your current level of stress? **High Moderate Low _____**
Are you currently seeing a psychologist? **Y/N____**
What is your occupation? _____
Do you engage in regular exercise? **None 1-2x/week 3-4x/week 5-7x/week _____**

If yes, what type of exercise?_____

Please rate your diet: **Poor Fair Moderate Good Excellent _____**

Typical

Breakfast _____

Lunch _____

Dinner_____

Fluid Intake _____