

Integrated Physical Therapy of Littleton

9200 West Cross Drive Suite 400

Littleton, CO 80127 303-904-8133

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question leave it blank and your therapist will assist you. Thank you!

Name: _____ Leisure Activities: _____

Occupation: _____

ALLERGIES: List any medication(s) you are allergic to: _____
Are you latex sensitive? Yes No List any other allergies we should know about: _____
Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

Please check (✓) any of the following whose care you are under:

- | | | |
|--|--|---|
| <input type="checkbox"/> Medical Doctor (MD) | <input type="checkbox"/> Psychiatrist/Psychologist | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Osteopath | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Other _____ |

Date of Last Physical Examination: _____ If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

Have you EVER been diagnosed as having any of the following conditions?

- | | | |
|-----|----|--|
| YES | NO | Cancer, If YES, what kind: _____ |
| YES | NO | Heart Problems, If YES, what kind: _____ |
| YES | NO | Heart Disease, If YES, what kind: _____ |
| YES | NO | Pacemaker |
| YES | NO | High Blood Pressure |
| YES | NO | Circulation Problems |
| YES | NO | Asthma |
| YES | NO | Stomach Ulcers |
| YES | NO | Chemical Dependency (i.e., alcoholism) |
| YES | NO | Thyroid Problems |
| YES | NO | Diabetes |
| YES | NO | Multiple Sclerosis |
| YES | NO | Rheumatoid Arthritis |
| YES | NO | Artificial Joints |
| YES | NO | Other Arthritic Conditions |
| YES | NO | Emphysema |
| YES | NO | Epilepsy |
| YES | NO | Migraine Headaches |
| YES | NO | Depression |
| YES | NO | Hepatitis |
| YES | NO | Tuberculosis |
| YES | NO | Stroke |
| YES | NO | Immune Suppressed (HIV/AIDS) |
| YES | NO | Kidney Disease, If YES, what kind: _____ |
| YES | NO | Blood Clots |
| YES | NO | Osteoporosis |
| YES | NO | Other: _____ |

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During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

Date	Surgery or Hospitalization / Reason	Date	Surgery or Hospitalization / Reason
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____
5. _____	_____	6. _____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, and sprains) and the approximate date of injury:

Date	Injury	Date	Injury
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

YES	NO	Diabetes	YES	NO	Cancer
YES	NO	Heart Disease	YES	NO	Alcoholism (Chemical Dependency)
YES	NO	High Blood Pressure	YES	NO	Depression
YES	NO	Stroke	YES	NO	Kidney Disease
YES	NO	Inflammatory Arthritis (Rheumatoid, Ankylosing)			

List medications you have taken in the last week that were prescribed by your physician: 1.) _____

2.) _____ 3.) _____ 4.) _____

List any other physician-prescribed medications you are currently taking (including pills, injections, and or skin patches):

1.) _____ 2.) _____ 3.) _____

List medications you have taken in the last week that were not prescribed by your physician: 1.) _____

2.) _____ 3.) _____ 4.) _____

How much caffeinated coffee or caffeine containing beverages do you drink per day? _____

Tobacco use: How many packs do you smoke per day? _____ for how many years? _____. If quit, when? _____

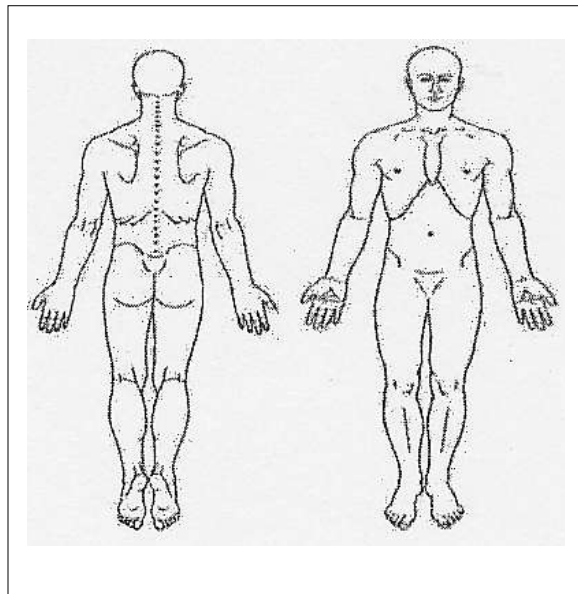
If one drink equals one beer or glass of wine, how much do you drink at an average sitting per week? _____

My pain level is usually: 0 1 2 3 4 5 6 7 8 9 10 (Zero = No Pain – 10 = Extreme Pain-going to hospital)

Have you recently noticed?

- YES NO Weight loss/gain
- YES NO Nausea/Vomiting
- YES NO Dizziness/Lightheadedness/Fainting
- YES NO Fatigue/Unexplained Muscle Fatigue
- YES NO Weakness
- YES NO Fever/Chills/Sweats
- YES NO Numbness or Tingling
- YES NO Tremors
- YES NO Seizures
- YES NO Double Vision
- YES NO Loss of Vision
- YES NO Eye Redness
- YES NO Skin Rash
- YES NO Problems Sleeping
- YES NO Sexual Difficulties
- YES NO Night Sweats
- YES NO Hearing Problems
- YES NO Joint/Muscle Swelling
- YES NO Easy Bruising
- YES NO Excessive Bleeding
- YES NO Difficulty Breathing
- YES NO Regular Cough
- YES NO Arm/Leg Swelling
- YES NO Heart Racing
- YES NO Difficulty Swallowing
- YES NO Heartburn/Indigestion
- YES NO Constipation/Diarrhea
- YES NO Blood in Stools
- YES NO Post Menopausal
- YES NO Problems Urinating
- YES NO Urinary Incontinence
- YES NO Blood in Urine
- YES NO Pregnant or think you might be
- YES NO Stress at Home or Work

Please draw your pain areas:



Please list your goals for therapy: _____

Patient signature: _____ Date

Therapist signature: _____ Date