MOLOKA'I GENERAL HOSPITAL

PHYSICAL THERAPY – Confidential Health History

Initial DOS: _____
Onset/Surgery: _____
Referred by: _____
PCP: _____
D.O.B. _____

ANY CHANGES / UPDATES WE SHOULD KNOW ABOUT? PLEASE LET OUR STAFF KNOW, THANK YOU.

☐ACUTE ☐SNF ☐ER ☐EROBS ☐OP ☐WComp ☐NFault

PERSON COMPLETING THIS FORM:
☐ Patient ☐ Family (relationship): _____ ☐ Other: _____

Chief Problem or Complaint? _____

Describe your current symptoms: ☐Pain ☐ Dull Ache ☐ Sharp ☐ Burning ☐ Stabbing

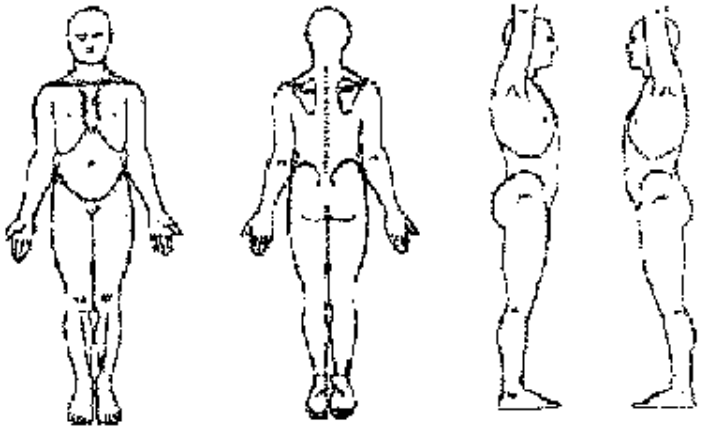
☐ Throbbing ☐ Weakness ☐ Numbness / Tingling ☐ Other: _____

Are your symptoms: ☐ Constant ☐ Increasing ☐ Intermittent ☐ Decreasing ☐ Staying the same

What makes your symptoms worse? _____

What makes your symptoms better? _____

Please indicate painful areas by *shading* these models.



PAIN: How much do you have right now?
(Please circle a number.)

Pain Rating Scale

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
	None				Moderate					Severe		

Since your symptoms began have you had: ☐ Fever / Chills ☐ Any numbness in genital/anal area

☐ Dizziness / Fainting ☐ Unexplained weight loss ☐ Night sweats / Pain ☐ Problems: vision / hearing

☐ Any difficulty with bladder / bowel function ☐ None of the above

Has previous or current care been sought for this problem? ☐ No ☐ Yes_____

_____

Diagnostic Tests: Please check all that apply and list date. ☐ None ☐ EMG _____ ☐ MRI _____

☐ X-rays _____ ☐ CT Scan _____ ☐ Injection _____ ☐ Bone Scan _____

☐ Other _____

GENERAL HEALTH:

Age: ____ Height: _____ Weight: _____ Dominant hand: (please circle) **R** or **L**

Smoker? ☐ Yes ☐ No ____ smokes _____/ day

Alcohol? ☐ Yes ☐ No ____alcohol _____/day or ____/week

Exercise? ☐ Yes ☐ No ____ exercise _____/day or ____/week

HAVE YOU PREVIOUSLY HAD, OR PRESENTLY HAVE ANY OF THESE DISEASES OR CONDITIONS?

☐ High Blood Pressure	☐ Rheumatic Fever	☐ Osteoporosis
☐ Heart Problems	☐ Kidney / Bladder Trouble	☐ Recent Fracture: _____
☐ Chest Pain / Angina	☐ Liver Disease / Jaundice	☐ Skin Disease
☐ Heart Attack	☐ Hepatitis	☐ Short of Breath
☐ Bleeding Tendency	☐ Diabetes	☐ Lung Problems / Asthma
☐ Anemia	☐ Thyroid Trouble	☐ Gout
☐ Pacemaker	☐ Overweight	☐ Arthritis: _____
☐ Stroke / CVA	☐ Currently Pregnant (due: ____)	☐ Hernia
☐ Epilepsy / Seizures	☐ HIV / AIDS	☐ Ulcers
☐ Head Trauma	☐ Sexually Transmitted Disease	☐ Cancer / Tumor: _____
☐ Dizziness	☐ Depression	☐ Metal Implants
☐ Glaucoma	☐ Psychiatric Illness	☐ Other:

Medications: Please list <u>all</u> medications currently being taken along with dosage, if known, and frequency.
☐ See attached _____

Surgery: Please list all surgeries and approximate date. _____

_____

LEARNING: What is the easiest way for you to learn? (Check all that apply)
☐ Seeing (pictures / videotapes / written handouts) ☐ Doing (hands-on)

☐ Hearing (verbal explanation / audiotape)

BARRIERS TO LEARNING
☐ None ☐ Language ☐ Psychological ☐ Hearing ☐ Religion ☐ Motivation

☐ Literacy ☐ Mental Status ☐ Seeing ☐ Cultural ☐ Other: _____

WHAT ARE YOUR GOALS FOR THERAPY? ☐ Decrease pain ☐ Improve sleep ☐ Reach
☐ Increase sitting / standing / walking ☐ Lift ☐ Other: _____

WORK INFORMATION

Occupation / Employment: _____ ☐ Retired: When _____

Physical activities at work: ☐ Sitting ☐ Standing ☐ Computer use ☐ Phone use ☐ Driving

☐ Repetitive lifting ☐ Heavy equipment operation ☐ Heavy lifting

Current working status: ☐ Full duty ☐ Restricted duty _____ ☐ Work days missed _____

Information Reviewed By: _____ _____
Physical Therapist or PT CMA Signature Date