

# OUTPATIENT/ CLIENT HISTORY MANAGEMENT FORM

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Male  Female   
 Last First MI Jr/Sr/Other MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
 Street/PO Box City State Zip

TYPE OF INSURANCE: Insurer: \_\_\_\_\_  Medicare  Self-pay  Other  Workers' Comp

<p>1. <b>ARE YOU:</b>  <input type="checkbox"/> Right-handed <input type="checkbox"/> Left handed</p>	<p>6. <b>HAVE YOU COMPLETED AN ADVANCE DIRECTIVE?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%; padding: 5px;"> <p>2. <b>RACE:</b>  <input type="checkbox"/> American Indian  <input type="checkbox"/> Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Native Hawaiian or Other Pacific Islander  <input type="checkbox"/> Caucasian</p> </td> <td style="width: 33%; padding: 5px;"> <p><b>ETHNICITY:</b>  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Non Hispanic or Latino  <input type="checkbox"/> Interpreter Needed</p> </td> <td style="width: 33%; padding: 5px;"> <p><b>LANGUAGE:</b>  <input type="checkbox"/> English understood  <input type="checkbox"/> Interpreter needed  <input type="checkbox"/> Language spoken most often: _____</p> </td> </tr> </table>	<p>2. <b>RACE:</b>  <input type="checkbox"/> American Indian  <input type="checkbox"/> Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Native Hawaiian or Other Pacific Islander  <input type="checkbox"/> Caucasian</p>	<p><b>ETHNICITY:</b>  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Non Hispanic or Latino  <input type="checkbox"/> Interpreter Needed</p>	<p><b>LANGUAGE:</b>  <input type="checkbox"/> English understood  <input type="checkbox"/> Interpreter needed  <input type="checkbox"/> Language spoken most often: _____</p>	<p>7. <b>WHO REFERRED YOU TO PHYSICAL THERAPY/THERAPIST:</b>          _____</p>
<p>2. <b>RACE:</b>  <input type="checkbox"/> American Indian  <input type="checkbox"/> Alaska Native  <input type="checkbox"/> Asian  <input type="checkbox"/> Black or African American  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Native Hawaiian or Other Pacific Islander  <input type="checkbox"/> Caucasian</p>	<p><b>ETHNICITY:</b>  <input type="checkbox"/> Hispanic or Latino  <input type="checkbox"/> Non Hispanic or Latino  <input type="checkbox"/> Interpreter Needed</p>	<p><b>LANGUAGE:</b>  <input type="checkbox"/> English understood  <input type="checkbox"/> Interpreter needed  <input type="checkbox"/> Language spoken most often: _____</p>		
<p>3. <b>CULTURAL/ RELIGIOUS:</b> Any customs or religious beliefs or wishes that might affect care:          _____          _____</p>	<p>8. <b>EMPLOYMENT/ PROFESSION (JOB/SCHOOL/PLAY):</b>  <input type="checkbox"/> Work full-time outside of home              Type of work _____  <input type="checkbox"/> Working part-time outside of home  <input type="checkbox"/> Working full-time from home  <input type="checkbox"/> Working part-time from home  <input type="checkbox"/> Homemaker  <input type="checkbox"/> Student  <input type="checkbox"/> Retired (type of work) _____  <input type="checkbox"/> Unemployed</p>			
<p>4. <b>EDUCATION:</b>  <input type="checkbox"/> Highest grade completed (Grade 1 thru 12): _____  <input type="checkbox"/> Some college/ technical school  <input type="checkbox"/> College graduate  <input type="checkbox"/> Graduate school/ advanced degree</p>	<p>9. <b>WHERE DO YOU LIVE:</b>  <input type="checkbox"/> Private home  <input type="checkbox"/> Private apartment  <input type="checkbox"/> Rented room  <input type="checkbox"/> Board and care/ assisted living/ group home  <input type="checkbox"/> Homeless (with or without shelter)  <input type="checkbox"/> Long-term care facility (nursing home)  <input type="checkbox"/> Hospice  <input type="checkbox"/> Other: _____</p>			
<p>5. <b>WITH WHOM DO YOU LIVE:</b>  <input type="checkbox"/> Alone  <input type="checkbox"/> Spouse only  <input type="checkbox"/> Spouse and Other(s)  <input type="checkbox"/> Child (not spouse)  <input type="checkbox"/> Other relative(s) (not spouse or children)  <input type="checkbox"/> Group setting  <input type="checkbox"/> Personal care attendant  <input type="checkbox"/> Other: _____</p>	<p>10. <b>DOES YOUR HOME HAVE:</b>  <input type="checkbox"/> Stairs but no railing  <input type="checkbox"/> Stairs with railing  <input type="checkbox"/> Ramps  <input type="checkbox"/> Elevator  <input type="checkbox"/> Uneven terrain  <input type="checkbox"/> Assistive devices (e.g., bathroom):          _____  <input type="checkbox"/> Any obstacles:          _____          _____</p>			



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16. **CLINICAL TESTS:** *(Within the past year, have you had any of the following tests? Check all that apply):*

- Angiogram
- Arthroscopy
- Biopsy
- Blood tests
- Bone mineral density
- Bone scan
- Bronchoscopy
- CT scan
- Doppler ultrasound
- Echocardiogram
- EEG (electroencephalogram)
- EKG (electrocardiogram)
- EMG (electromyogram)
- X-rays
- Mammogram
- MRI
- Myleogram
- NCV (nerve conduction velocity)
- Pap smear
- Pulmonary function test
- Spinal tap
- Stool tests
- Stress test (e.g., treadmill, bicycle)
- Urine tests
- Other

17. **MEDICAL/ SURGICAL HISTORY:** *Please check if you have ever had any of the following:*

- 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
- Depression
- Multiple sclerosis
- Muscular dystrophy
- Parkinson disease
- Seizures/ epilepsy
- Allergies
- Developmental or growth problems
- Thyroid problems
- Cancer
- Infectious disease (e.g., TB, hepatitis)

17. **MEDICAL/SURGICAL HISTORY (Cont.)**  
*Please check if you have ever had any of the following:*

- Kidney problems
- Repeated infections
- Ulcers/ stomach issues
- Skin diseases
- Other: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*Within the past year, have you had any of the following symptoms (check all that apply):*

- Chest pain
- Heart palpitations
- Cough
- Hoarseness
- Shortness of breath
- Dizziness or blackouts
- Coordination problems
- Weakness in arms or legs
- Loss of balance
- Difficulty walking
- Joint pain or swelling
- Pain at night
- Difficulty sleeping
- Loss of appetite
- Nausea/ vomiting
- Difficulty swallowing
- Bowel problems
- Weight loss/ gain
- Urinary problems
- Fever/ chills/ sweats
- Headaches
- Hearing problems
- Vision problems
- Other: \_\_\_\_\_  
 \_\_\_\_\_

**Have you ever had surgery:**  Yes  No

*If yes, please describe and indicate dates:*

\_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_  
 \_\_\_\_\_ Date: \_\_\_\_\_

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**17. MEDICAL/SURGICAL HISTORY (Cont.)**

*Please check if you have ever had:*

- Light headedness
- Dizziness
- Sensation of spinning or vertigo (while going from lying to sitting, sitting to standing or during head movements)
- Visual problems
  - When was your last eye exam: \_\_\_\_\_
- Eye surgery
- Hearing difficulties
  - When was your last hearing exam: \_\_\_\_\_

**For men only:**

Have you been diagnosed with prostate disease:

- Yes     No

**For women only:** *Have you been diagnosed with:*

- Pelvic inflammatory disease:         Yes    No
- Endometriosis:                                 Yes    No
- Trouble with your period:                 Yes    No
- Complicated pregnancies or             Yes    No  
deliveries:
- Pregnant or think you are:                 Yes    No
- Other gynecological or                     Yes    No  
obstetrical difficulties:

*If yes, please describe:*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**18. CURRENT CONDITION(S)/ CHIEF COMPLAINTS:**

- Describe the problem(s) for which you are seeking PT: \_\_\_\_\_  
\_\_\_\_\_
- When did the problem(s) begin: Date: \_\_\_\_\_  
What happened: \_\_\_\_\_  
\_\_\_\_\_
- Have you ever had the problem before:  
 Yes     No  
If yes, what did you do for the problem(s): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**18. CURRENT CONDITION(S)/ CHIEF COMPLAINTS (Continued):**

- Did the problem get better:    Yes    No
- How long did the problem last: \_\_\_\_\_
- How are you taking care of the problem now:  
\_\_\_\_\_  
\_\_\_\_\_
- What makes the problem better: \_\_\_\_\_  
\_\_\_\_\_
- What makes the problem worse: \_\_\_\_\_  
\_\_\_\_\_
- What are your goals for physical 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
- Osteopathy
- Pediatrician
- Podiatrist
- Primary care physician
- Rheumatologist
- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

