# BodiKey Physical Therapy

Patient Information Sheet



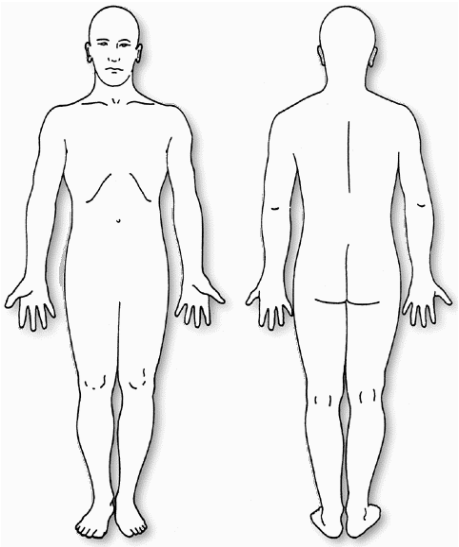
***Welcome back to our practice!***
***Please help us serve you better by taking a few minutes to provide the following information.***

| | | | | |
|---|---|---|---|---|
| Name: | | | Today's date: | |
| | Last Name | First Name | DOB: | |
| Has your contact information (address, telephone or email) changed? | | | Yes | No |
| ***Primary Care Physician*** | | | | |
| Name: | | Date of next visit | | |
| ***Specialist Physician*** | | | | |
| Name: | | Date of next visit | | |

***The following is very important in our evaluation process.***
***Please fill out these forms as specifically as possible to provide us with a clear picture of your present pain and functional status.***

| |
|---|
| **What is the primary issue/problem that brings you in today?** |
| |
| **Are there any other issues or problems?** |
| |
| **As a result, I am now having difficulty with:** |
| |
| **Are you currently experiencing pain as a result of these symptoms?** |
| |
| **When did your symptom(s) begin?**<br>**Date:** |
| |

**Please shade in areas where you have pain, discomfort, or tension.**



| | | |
|---|---|---|
| **Please rate your pain in the last 24-72 hours**<br>Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain. | At its worst | |
| | At its best | |
| | At present | |
| | Night (sleeping) | |

| | |
|---|---|
| At what time of day are your symptoms the worst? | |
| At what time of day are your symptoms the best? | |
| What activities increase your pain? | |
| What activities decrease your pain? | |

| What other types of treatment have you had for this problem? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Massage | | Bodywork | | Physical Therapy | | Myofascial Release | | Chiropractic | | Surgery |
| Other Medical Treatment: (Please Describe) | | | | | | | | | | | |

| Check the box if you have had any of the following medical conditions? | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Diabetes | | Lung disease | | Weight change | | Varicose veins | | Neurological problems | | Pregnancy |
| | Rheumatic fever | | Osteoporosis | | Migraine headaches | | Epilepsy / seizures | | Stroke | | Blackouts |
| | Heart Murmur | | Malignancy | | Arthritis | | Broken bones (fracture | | Metal implants | | High blood pressure |
| | Circulatory problems | | Liver disease | | Heart disease / pacemaker | | Kidney disease | | **Others (explain below)** | | |
| | | | | | | | | | | | |

| List past medical history and dates of occurrence. Include surgeries, accidents and other traumas. |
|---|
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| |
| |
| |

| List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies). | | | |
|---|---|---|---|
| Medication | For treatment of | Dose / Amount per day | Effectiveness |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| | | | | |
|---|---|---|---|---|
| Do you have any skin or medication allergies? | | | Yes | No |
| Please Describe: | | | | |
| Do you smoke? | Yes | No | If “Yes” – How much? | |
| When did you quit? | | | If not, Would you like to quit? | |
| Is there a chance you may be pregnant at this time? | | | Yes | No |

| | | |
|---|---|---|
| Do you engage in regular exercise? | Yes | No |
| What type and how often? | | |
| Are you able to exercise now? | Yes | No |
| Do you have discomfort, shortness of breath, or pain with exercise? | Yes | No |
| Please Describe: | | |

***If sleep is a problem, answer these questions:***

| | | |
|---|---|---|
| Do you have trouble falling asleep? | Yes | No |
| Is your sleep restful? | Yes | No |
| Do you find it difficult to lie down? | Yes | No |
| Do you find it difficult to change positions in bed? | | |
| How many times do you wake in the night? | | |
| How long before you fall back to sleep? | | |

**List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).**
**If you are no longer able to perform an activity, your tolerance would be "0".**

| Task / Activity | Tolerance (minutes/hours) |
|---|---|
| | |
| | |
| | |
| | |
| | |

| | | |
|---|---|---|
| **I walk for** | | **minutes before needing to rest** |
| **I stand for** | | **minutes before needing to sit** |
| **I sit for** | | **minutes before needing to change positions/get up** |

| | | |
|---|---|---|
| Do you have trouble getting up from a chair? | Yes | No |
| Do you have trouble putting on your shoes and socks? | Yes | No |
| Do you have difficulty climbing stairs? | Yes | No |

**Patient Goals**
**Please list the activities that you would like to be able to do as a result of therapy.**

| Task / Activity | Duration / How Often | By When |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| **Other Goals?** | | |
| | | |
| | | |