P·E·A·K PHYSICAL THERAPY CENTER

Performance Enhancement & Kinetic Physical Therapy
2041 Newcastle Ave Cardiff, CA 92007
Tel. 760.230.5432 • Fax 760.655.4336
www.peakptc.com

Client Name: _____ Date: _____

1. MEDICAL SURGICAL HISTORY (Check all that apply)

a. Please check if you have ever had:

◯ (1) Arthritis
◯ (2) Broken bones/Fractures
◯ (3) Osteoporosis
◯ (4) Blood disorders
◯ (5) Circulation/vascular problems
◯ (6) Heart problems
◯ (7) High blood pressure
◯ (8) Lung problems (e.g.. Tuberculosis, hepatitis)
◯ (9) Stroke
◯ (10) Diabetes/high blood sugar
◯ (11) Low blood sugar/ hypoglycemia
◯ (12) Head injury
◯ (13) Multiple sclerosis
◯ (14) Muscular dystrophy
◯ (15) Parkinson disease
◯ (16) Seizures/epilepsy
◯ (17) Allergies
◯ (18) Developmental or growth problems
◯ (19) Thyroid problems
◯ (20) Cancer
◯ (21) Infectious disease
◯ (22) Kidney problems
◯ (23) Repeated infections
◯ (24) Ulcers/stomach problems
◯ (25) Skin diseases
◯ (26) Depression
◯ (27) Other: _____

b. Within the past year, have you had any of the symptoms?

◯ (1) Chest pain
◯ (2) Heart palpitations
◯ (3) Cough
◯ (4) Hoarseness
◯ (5) Shortness of breath
◯ (6) Dizziness or blackouts
◯ (7) Coordination problems
◯ (8) Weakness in arms or legs
◯ (9) Loss of balance
◯ (10) Difficulty walking
◯ (11) Joint pain or swelling
◯ (12) Pain at night
◯ (13) Difficulty sleeping
◯ (14) Loss of appetite
◯ (15) Nausea/vomiting
◯ (16) Difficulty swallowing
◯ (17) Bowel problems
◯ (18) Weight loss/gain
◯ (19) Urinary problems
◯ (20) Fever/chills/sweats
◯ (21) Headaches
◯ (22) Hearing problems
◯ (23) Vision problems
◯ (24) Other: _____

c. Have you ever had surgery? ◯ (1) Yes ◯ (2) No If yes, please describe: _____

2. CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

a. Describe the problem(s) for which you seek physical therapy: _____
b. When did the problem(s) begin (date)? Month _____ Year _____
c. What happened? _____
d. Have you ever had the problem(s) before? ◯ (1) Yes ◯ (2) No
If "Yes" please answer the following:
(a) What did you do for the problem(s)? _____
(b) Did the problem(s) get better? ◯ (1) Yes ◯ (2) No
(c) About how long did the problem(s) last? _____
e. How are you taking care of the problem(s) right now? _____
f. What makes the problem(s) better? _____
g. What makes the problem(s) worse? _____
h. What are your goals for physical therapy? _____
i. List anyone else you are seeing for the problem(s)? _____

3. FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

a. Difficulty with locomotion/movement:
◯ (1) Bed mobility
◯ (2) Transfers (such as moving from bed to chair, from bed to commode)
◯ (3) Gait (walking)
◯ (a) On level ◯ (c) On ramps
◯ (b) On Stair ◯ (d) On uneven terrain

◯ b. Difficulty with self-care (such as bathing, dressing, eating, toileting)
◯ c. Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependents)
◯ d. Difficulty with community and work activities/integration
◯ (1) Work/school ◯ (2) Recreation or play activity

4. MEDICATIONS

a. Did you take any prescription medications? ◯ (1) Yes ◯ (2) No If yes, please list: _____
b. Do you take any nonprescription medications?(check all that apply)

◯ (1) Advil/Aleve
◯ (2) Antacids
◯ (3) Ibuprofen/Naproxen
◯ (4) Antihistamines
◯ (5) Aspirin
◯ (6) decongestants
◯ (7) Herbal supplements
◯ (8) Tylenol
◯ (9) Other: _____

5. OTHER CLINICAL TESTS

a. Check any tests you have had performed for this condition.

◯ (1) MRI
◯ (2) X-rays
◯ (3) Other:

_____
_____
_____