Clinical Information Form

FYZICAL Therapy & Balance Centers of Rockville

Patient Name_____ ***(Please Print)*** Date _____/_____/_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Payer Source: ☐ Indemnity Insurance ☐ Medicare B ☐ Patient (Self pay) ☐ Workers' Comp ☐ Auto ☐ Other

Describe your symptoms_____

When did your symptoms first start? _____

How often do you experience your symptoms?

- ☐ Constantly (75-100% of the day)
- ☐ Frequently (50-75% of the day)
- ☐ Intermittently (25-50% of the day)
- ☐ Occasionally (0-25% of the day)

What words best describe your symptoms?

☐ Sharp	☐ Shooting	☐ Burning
☐ Heavy	☐ Throbbing	☐ Ache
☐ Tingling	☐ Dull	☐ Tight
☐ Stabbing	☐ Numb	☐ Pulling

Please rate your pain at its worst → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain currently → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

Please rate your pain at its best → (No pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe pain)

List any positions or activities that **increase** your symptoms _____

List any positions or activities that **decrease** your symptoms _____

Did you have any falls over the past year?
☐ Yes ☐ No *If yes, how many?* ____

Did you have an injury as a result of the fall?
☐ Yes ☐ No

Please check any of the following problems that apply to you:

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), Acquired Respiratory Distress Syndrome (ARDS), or Emphysema
- ☐ Angina
- ☐ Congestive Heart Failure or Heart Disease
- ☐ Heart Attack (Myocardial Infarction)
- ☐ High Blood Pressure
- ☐ Neurological Disease (such as Multiple Sclerosis or Parkinson's)
- ☐ Stroke or TIA
- ☐ Seizures
- ☐ Peripheral Vascular Disease (or Claudication)
- ☐ Headaches
- ☐ Diabetes Type I or II
- ☐ Gastrointestinal Disease (Ulcer, Hernia, Reflux, Bowell, Liver, Gall Bladder)
- ☐ Visual Impairments (such as Cataracts, Glaucoma, Macular Degeneration)
- ☐ Hearing Impairment (very hard of hearing, even with hearing aids)
- ☐ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Kidney, Bladder, Prostate, or Urination Problems
- ☐ Previous Accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Other Disorders
- ☐ Hepatitis, Tuberculosis, or other blood borne condition
- ☐ Prior Surgery
- ☐ Prosthesis / Implants
- ☐ Sleep Dysfunction
- ☐ Cancer
- ☐ None of the Above

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

Height: _____Feet _____Inches Weight: _____lbs.

Please respond to each question with the response that best describes you or your level of function over the past few days.

1. **Have you ever received treatment for this condition before?**
   - ☐ Yes
   - ☐ No

2. **How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking prior to the onset of your condition?**
   - ☐ At least three (3) times a week
   - ☐ Once or twice a week
   - ☐ Seldom or never

3. **Are you taking prescription medication for this condition?**
   - ☐ Yes
   - ☐ No

4. **How many days ago did your condition begin?**
   - ☐ 0 - 7 days
   - ☐ 8 - 14 days
   - ☐ 15 - 21 days
   - ☐ 22 - 90 days
   - ☐ 91 days to 6 months
   - ☐ Over 6 months

5. **How many surgeries have you had for the problem for which you are being treated?**
   - ☐ None
   - ☐ 1
   - ☐ 2
   - ☐ 3
   - ☐ 4 or more

What tests have you had for your symptoms? *(Please provide date. If not tested, leave blank)*

☐ X-rays _____ ☐MRI _____ ☐ CT Scan_____ ☐ DEXA Scan _____ ☐Other_____

Social History

Please list your exercise/recreational activities _____

Occupation_____ ☐employed (full duty) ☐employed (restricted duty) ☐disability ☐retired ☐student ☐unemployed

Patient Goals_____

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Current Functional Scale: _____

On a scale of 0 to 100, where 0 represents low function and 100 represents high function.

FOTO Average: _____

Predicted Improvement: _____

Based on patients with a similar profile.

RD 3/21/19