Clinical Information Form

FYZICAL Therapy & Balance Centers of Rockville

(Please Print)

Patient Name_____ Date _____/_____/_____

Describe your symptoms_____

When did your symptoms first start? _____

Height: _____

Weight: _____

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

Medical History

Check **ALL** of the conditions that apply to you:

☐ Allergies	☐ Concussion	☐ Fractures	☐ Incontinence	☐ Rheumatoid Arthritis
☐ Anemia	☐ Chemical Dependency	☐ Gall Bladder Issues	☐ Kidney Issues	☐ Seizures
☐ Anxiety	☐ Circulation Issues	☐ Headaches/Migraine	☐ Metal Implants	☐ Smoking
☐ Arthritis	☐ Currently Pregnant	☐ Head Injury	☐ MRSA	☐ Speech Issues
☐ Asthma	☐ Depression	☐ Hearing Impairments	☐ Multiple Sclerosis	☐ Stroke
☐ Autoimmune Disorder	☐ Diabetes	☐ Hepatitis	☐ Muscular Disease	☐ Thyroid disease
☐ Cancer	☐ Dizzy Spells	☐ High/Low Blood Press.	☐ Osteoporosis	☐ Tuberculosis
☐ Cardiac Conditions	☐ Emphysema/Bronchitis	☐ High Cholesterol	☐ Parkinsons	☐ Vision Issues
☐ Cardiac/Pacemaker	☐ Fibromyalgia	☐ HIV/Aids	☐ Tinnitus	
☐ Cardiac/Defibrillator		☐ Hysterectomy		

☐ Other_____

Have any immediate family members been treated for any of the above conditions? ☐ Yes ☐ No
If yes, please specify _____

Surgical History

Body region:_____ Surgery Type:_____ Date: ____/____/_____
Body region:_____ Surgery Type:_____ Date: ____/____/_____
Body region:_____ Surgery Type:_____ Date: ____/____/_____
Body region:_____ Surgery Type:_____ Date: ____/____/_____

Current Medications
(See Attached Medications form)

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

How many times a week do you complete at least 20 minutes of exercise? ☐ 3 or more ☐ 1-2 ☐ Seldom/Never
Please list your exercise/recreational activities _____
Occupation_____ ☐employed (full duty) ☐employed (restricted duty) ☐disability ☐retired ☐student ☐unemployed

Patient Goals_____