Orlando Physical Therapy

PATIENT'S NAME: McAuliff
Last First Middle Initial

Select:	**Y FOR YES**	**N FOR NO**		
Have you or any immediate family member *ever* been told to have:	**Self**		**Family**	
Cancer?	☐ Y	☐ N	☐ Y	☐ N
Diabetes?	☐ Y	☐ N	☐ Y	☐ N
High Blood Pressure?	☐ Y	☐ N	☐ Y	☐ N
Heart Disease?	☐ Y	☐ N	☐ Y	☐ N
Angina / Chest Pain?	☐ Y	☐ N	☐ Y	☐ N
Stroke?	☐ Y	☐ N	☐ Y	☐ N
Osteoporosis?	☐ Y	☐ N	☐ Y	☐ N
Rheumatoid Arthritis?	☐ Y	☐ N	☐ Y	☐ N

In the past 3 months, have you had or do you experience:	**Self**	
A change in YOUR Health?	☐ Y	☐ N
Nausea / Vomiting?	☐ Y	☐ N
Fever / Chills / Sweats?	☐ Y	☐ N
Unexplained weight loss?	☐ Y	☐ N
Numbness or tingling?	☐ Y	☐ N
Changes in appetite?	☐ Y	☐ N
Difficulty swallowing?	☐ Y	☐ N
Changes in bowel / bladder Functions?	☐ Y	☐ N
Shortness of breath?	☐ Y	☐ N
Dizziness?	☐ Y	☐ N
Upper respiratory infection?	☐ Y	☐ N
Urinary tract infections?	☐ Y	☐ N

I currently have difficulty-check all that apply

☐ Driving ☐ Getting up from a chair
☐ Walking ☐ Bending at the waist
☐ Standing ☐ Lifting

If you are accustomed to regular exercise, check the ones that are giving you difficulty now?

☐ Playing sports
☐ Running
☐ Calisthenics

Select:	**Y FOR YES**	**N FOR NO**		
Do you have a history of:	**Self**		**Family**	
Allergies / Asthma?	☐ Y	☐ N	☐ Y	☐ N
Headaches?	☐ Y	☐ N	☐ Y	☐ N
Bronchitis?	☐ Y	☐ N	☐ Y	☐ N
Kidney Disease?	☐ Y	☐ N	☐ Y	☐ N
Rheumatic Fever?	☐ Y	☐ N	☐ Y	☐ N
Ulcers?	☐ Y	☐ N	☐ Y	☐ N
STD?	☐ Y	☐ N	☐ Y	☐ N
Seizures?	☐ Y	☐ N	☐ Y	☐ N

Are your symptoms getting? (check one)

☐ Worse ☐ The Same ☐ Improving

Are you able to sleep at night? (check one)

☐ Fine ☐ Moderate difficulty
☐ Only with Medication

Do you have a problem with:

☐ Hearing ☐ Speech
☐ Vision ☐ Communication

How do you learn best?

☐ Seeing ☐ Doing ☐ Hearing

Do you / have you in the past smoked tobacco?

☐ Yes (_____/week x _____years)
☐ No Last tobacco Use:_____

Do you drink alcoholic beverages?

☐ Yes (_____/week) ☐ No

Date of Last Physical?_____

Medications Currently Using: (or attach list)

List any surgeries you have had:

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ **NO** ☐ **YES**
IF YES, WHAT MEDICATION(S)?

Prepared By:_____
Date:_____
Relationship To Patient, If not Self:_____

2014 S. Orange Ave., Sutie 200 B, Orlando, FL, 32806 **AND** *668 N. Orlando Ave Ste 1010, Maitland FL 32751*
Tel: (407) 273-3100 **Fax:** ***(407) 273-3102***

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