9061 E Frontage Rd
Palmer, Alaska 99645

Recovery Waters
PHYSICAL THERAPY

Phone: 907-331-6992
Fax: 907-802-6559

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you.

Name: _____

What is your complaint or problem? _____

When did your problem begin? _____

What to you hope to achieve with PT? _____

Height: _____ Weight: _____

Pain? ☐ No ☐ Yes (**If yes,** where and intensity 0-10, 0 no pain - 10 most severe pain)_____

_____

Allergies? ☐ No ☐ Yes (to what?): _____

Any falls over last 12 months? ☐ No ☐ Yes (how often?): _____

Past Medical History		
Do you ***now or have you ever had***:		
☐ Diabetes (type): _____ ☐ High Blood Pressure ☐ Low Blood Pressure ☐ **Congestive Heart Failure/cardiac edema** ☐ Heart Attack ☐ Varicose veins ☐ Venous Insufficiency ☐ Hypothyroidism ☐ Hyperthroidism ☐ **Kidney Failure** ☐ Auto-immune disease ☐ Migraines ☐ Back pain ☐ Osteoporosis ☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Fibromyalgia ☐ Altered sensation ☐ Wound(s) ☐ Latex Allergy ☐ Cancer (type):_____ _____	☐ Epilepsy/Seizures ☐ Double Vision ☐ Macular Degeneration ☐ Vision Impairments ☐ Hard of hearing ☐ Hepatitis ☐ Liver disease ☐ HIV/AIDS ☐ Asthma ☐ COPD ☐ Cellulitis ☐ Active infection ☐ Abdominal aortic aneurysm ☐ Diverticulitis ☐ **Severe arteriosclerosis (ABI 0.49 or less)** ☐ Inflammatory bowel ☐ Chrohn's disease ☐ Ulcerative colitis ☐ Bruise easily ☐ Hyper-flexibility	☐ Scoliosis ☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ Traumatic Brain Injury ☐ Stroke/TIA ☐ Anxiety ☐ Depression ☐ Bipolar ☐ Schizophrenia ☐ Psychiatric Illness ☐ Dementia/Alzheimer's ☐ Asperger's/Autism ☐ Skin Disorder ☐ Blood Clots ☐ Ehlers-Danlos Syndrome ☐ Urinary Incontinence ☐ Currently Pregnant ☐ Breast Feeding ☐ Dizziness/Fainting ☐ Other: _____ _____ _____

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Past Surgical History (include date of surgery)	

Medication List (Including Over the Counter)	
(Please list name of drug, dosage, and frequency)	

Social		
Lives with: ☐ Alone ☐ _____	Stairs at Home: ☐ None ☐ # of stairs: _____	Daily Task: ☐ Cooking ☐ Cleaning ☐ Pet care ☐ Childcare ☐ Working a job ☐ Yard work ☐ Snow removal
Occupation:		
Physical Demands Required for Job:		

Equipment at Home		
☐ Manual Wheelchair	☐ Shower Chair/Bench	☐ Hospital Bed
☐ Electric Wheelchair	☐ Reacher	☐ Standard Walker
☐ Scooter	☐ Bedrails	☐ Walker with Seat
☐ Grab Bars in Shower	☐ Bedside Commode	☐ Single Point Cane
☐ Grab Bars by Toilet	☐ Compression Hose	☐ Quad Cane
☐ Raised Toilet Seat	☐ Compression Wraps	☐ Gait Belt

Current Exercise: _____

Exercise Equipment Available to me: _____