PT360°
Better Together
Employee Owned Physical Therapy Cooperative

# Initial Health Status

**Patient Name**: _____DOB:_____

**Subscriber ID#:** _____ Insurance Carrier: _____**Primary Language**: _____

**Describe Your Current Problem and How It Began**:

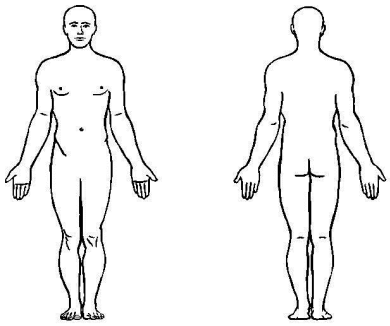
_____

_____

_____

**Onset date/Surgery date**: _____

Indicate below where you have pain or other symptoms



Is This? ☐ Work related ☐ Auto Related ☐ Not Applicable

**How Often are your symptom(s) present?**

☐ Constantly (76-100% of the day) ☐ Occasionally (26-50% of the day)
☐ Frequently (51-75% of the day ☐ Intermittently (0-25% of the day)

**Describe the nature of your pain:**

☐ Sharp ☐ Dull ache ☐ Numb ☐ Shooting ☐ Burning ☐ Tingling

**How is your condition changing?**

☐ Getting Better ☐ Not Changing ☐ Getting Worse

**Current complaint (how you feel today):**

[_____]

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

**In the past week, how much has your pain interfered with you daily activities (e.g., work, social activities, or household chores)?**

[_____]

No Pain 0 1 2 3 4 5 6 7 8 9 10 Unbearable pain

**Check if you have difficulty:** ☐ Seeing ☐ Hearing ☐Talking ☐ Memory ☐ Swallowing

**What is your most effective learning method**: ☐ Seeing ☐ Hearing ☐ Talking ☐ Doing ☐ Pictures

**In general would you say your overall health right now is:**

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

**Have you had x-rays, MRI and CT scan for your area(s) of Complaint?** ☐ Yes ☐ No

Date(s) Taken: _____ What area(s) were taken: _____

_____

_____

***-> PLEASE COMPLETE THE REVERSE SIDE ->***

**Please check all of the following that apply to you:**

- ☐ Alcohol/Drug Dependent
- ☐ Recent Fever
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Cardiac Condition
- ☐ Stroke (Date): _____
- ☐ Dizziness/Fainting
- ☐ Cancer/Tumor (Explain) _____
  _____
- ☐ Osteoporosis
- ☐ Other Health Problems (Explain) _____
  _____
- ☐ Numbness (location) _____
- ☐ Urinary Problems
- ☐ Currently Pregnant, # Weeks_____
- ☐ Abnormal Weight ☐ Gain ☐ Loss
- ☐ Pain Unrelieved by Position or Rest
- ☐ Pain at Night
- ☐ Surgeries _____
  _____
- ☐ Tobacco Use – Type _____
  Frequency _____/Day_____
- ☐ Current Medications: _____
  _____
  _____

**Allergies**: _____
_____

**Who have you seen for your condition before today?**

☐ No One ☐ **VNA** ☐Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Massage Therapist

☐ Occupational Therapist ☐ Athletic Trainer ☐ Acupuncturist ☐ Other: _____

**What treatment did you receive and when? __**_____
_____

**What is your occupation? _____**

☐ I certify to the best of my knowledge, the above information is complete and accurate.

☐ I agree to notify this provider/practitioner immediately when I have changes in my health condition in the future.

☐ I understand that this provider/practitioner may need to contact/consult my physician. Therefore, I give authorization to this provider/practitioner to contact my physician, if necessary.

**Patient/Responsible Party Signature:_____Date_____**

**The cancel/no show policy was reviewed with the patient and the patient has agreed to this policy. ☐**

**The HEALTH SURVEY was reviewed with the patient:**

_____ _____
Provider/Physical Therapist Date