STRIDE
PHYSICAL THERAPY
Take the Next Step

Please complete this confidential form prior to your appointment, scan and email it to Stridehometherapy@gmail.com

## 1. CLIENT INFORMATION

Name: _____Date of Birth:_____

Address: (City/State/Zip)_____
Phone: _____ Email:_____
Emergency Contact: _____ Phone: _____
Primary Care Provider:_____ Phone: _____
Who may we thank for referring you? _____

## 2. RECENT SYMPTOMS

Briefly Describe what you would like to address at our upcoming Visit:

_____

_____

_____

_____

Pain Scale (0-10): Current: ____ Best (24hrs): ____ Worst (24hrs):_____
What makes symptoms worse? _____
What makes symptoms better? _____
Previous Imaging?: (X-Ray, MRI, etc.) _____

Please check those CURRENT Issues which apply with dates/time frames:

- ☐ Cough / Runny Nose _____
- ☐ Chest Tightness / Difficulty Breathing_____
- ☐ Loss of Taste or Smell _____
- ☐ Numbness/Tingling (Arms/Hands or Legs/Feet) _____
- ☐ Weakness (Hands/Grip or Muscle Fatigue) _____
- ☐ Fever / Chills / Sweats _____
- ☐ Dizziness / Fainting / Lightheadedness _____
- ☐ Changes in Bowel/Bladder Function _____
- ☐ Falls in the past 6 months (how many?) _____
- ☐ Vision Changes / Ringing in Ears _____
- ☐ Headaches (Location/Duration) _____

## 3. BRIEF MEDICAL HISTORY

Please indicate if you have a history of any of the following:

- ☐ Cancer
- ☐ Heart Disease
- ☐ Circulation problems: Blood clots, Vascular disease, Anemia
- ☐ High or low blood pressure
- ☐ Stroke
- ☐ Lung problem: Pneumonia, Asthma
- ☐ Diabetes
- ☐ Osteoporosis/osteopenia
- ☐ Osteoarthritis
- ☐ Epilepsy or seizures
- ☐ Light sensitivity
- ☐ Skin sensitivity
- ☐ Light sensitivity
- ☐ Autoimmune Disease Rheumatoid arthritis
- ☐ Thyroid problems
- ☐ Obesity/anorexia
- ☐ Concussion/Head injury Headaches, Migraines Sinus problems
- ☐ Eye or vision problem
- ☐ Chemical dependency, alcoholism
- ☐ Depression, Anxiety

Allergies: _____

_____

## 4. LIFESTYLE & ACTIVITY

Occupation: _____

Hours of Sleep: _____

Sports/Hobbies: (e.g., Golf, Running, Cycling, Lifting, etc.) _____

_____

_____

Tobacco Use: Yes No (Packs per day:_____).
Alcohol Consumption:_____drinks per week.

## 5. MEDICATIONS

Consider reviewing your medications. The following medication classes can increase your fall risk.

- ☐ Opioids
- ☐ Antipsychotics
- ☐ Hypoglycemics

If you are unsure, I can help identify these. Any changes, however, will need to come from your PCP.

## 6. GOALS

_____

_____

_____