DONNA BEHR LLC
PHYSICAL THERAPY

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MEDICAL HISTORY

Patient Name _____ Date of Birth _____

EXISTING OR RELEVANT PREVIOUS CONDITIONS – please check if applicable

Allergies (incl latex)	O Yes O No	Dizzy Spells	O Yes O No	MRSA	O Yes O No
Anemia	O Yes O No	Emphysema/Bronchitis	O Yes O No	Multiple Sclerosis	O Yes O No
Anxiety	O Yes O No	Fibromyalgia	O Yes O No	Muscular Disease	O Yes O No
Arthritis	O Yes O No	Fractures	O Yes O No	Osteoporosis	O Yes O No
Asthma	O Yes O No	Gallbladder Problems	O Yes O No	Parkinsons	O Yes O No
Autoimmune Disorder	O Yes O No	Headaches	O Yes O No	Rheumatoid Arthritis	O Yes O No
Cancer	O Yes O No	Hearing Impairment	O Yes O No	Seizures	O Yes O No
Cardiac Conditions	O Yes O No	Hepatitis	O Yes O No	Smoking	O Yes O No
Cardiac Pacemaker	O Yes O No	High Cholesterol	O Yes O No	Speech Problems	O Yes O No
Chemical Dependency	O Yes O No	High/Low Blood Pressure	O Yes O No	Strokes	O Yes O No
Circulation Problems	O Yes O No	HIV/AIDS	O Yes O No	Thyroid Disease	O Yes O No
Currently Pregnant	O Yes O No	Incontinence	O Yes O No	Tuberculosis	O Yes O No
Depression	O Yes O No	Kidney Problems	O Yes O No	Vision Problems	O Yes O No
Diabetes	O Yes O No	Metal Implants	O Yes O No		

Please list any other conditions _____

CURRENT MEDICATIONS – list or attach copy

Medication Name	Dosage	Frequency	Purpose of Medication

SUPPLEMENTS

Supplement Name	Dosage	Frequency	Purpose of Supplement

SURGICAL HISTORY AND ANY DIAGNOSTIC TESTING

Body Region	Surgery Type/Diagnostic Testing	Date

FALL HISTORY – please answer Yes or No

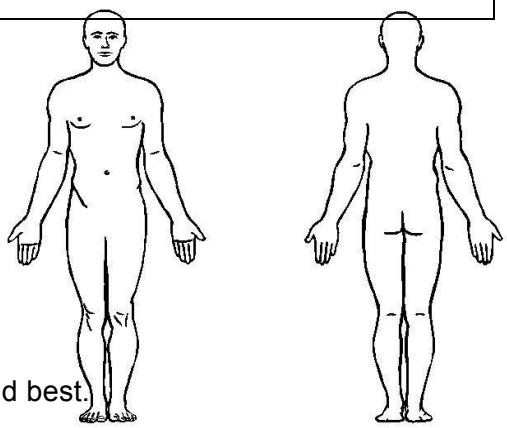
Is this injury a result of a fall in the past year? _____ Have you had 2 or more falls in the past year? _____

Do you feel at risk for falls? _____

DIETARY HABITS – please indicate what you typically consume within each category

Breakfast	
Lunch	
Dinner	
Snacks	
Beverages please include alcoholic, non-alcoholic and water	

PATIENT-SPECIFIC FUNCTIONAL SCALE



Height* _____ Weight*_____
(*required by Medicare)

On the pictures to the right, please indicate the location of your issues.

On the scale below, please indicate your level of discomfort at its worst and best.

0 1 2 3 4 5 6 7 8 9 10
0 = No discomfort 10 = Extreme discomfort

Please identify up to 3 activities that you are unable to do or are having difficulty with (i.e., getting dressed, walking your dog, yard work, sports, etc.).

Activity	Score	✔ Most Limited

Please score each activity using the scale below:

0 1 2 3 4 5 6 7 8 9 10
Able to perform activity at the same level as before problem — Unable to perform activity

Signature _____