Inspire Physical Therapy, Pedatric Orthopedics and Sports Medicine

1. **Please enter the patient's information.**

First Name: _____ Middle Initials: _____ Last Name: _____ Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Address: _____ Apt./Unit #: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Preferred contact method:
○ Mobile Phone ○ Home Phone ○ Work Phone
○ Email

2. **Please describe your current health concern and how it began - in order of priority:**

	Health Concern	When it began
1		
2		
3		
4		

3. **Current complaint**

Please describe: _____

0 - Not difficult / 10 - Unbearable
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

4. **How long have you had this condition?**

_____
_____
_____
_____

5. How does it impact your quality of life?

6. Have you seen a physician or other health practitioner about this? If 'yes', when? What was the diagnosis (if any)?

7. Describe any treatment you received and the results:

8. What aggravates this condition?

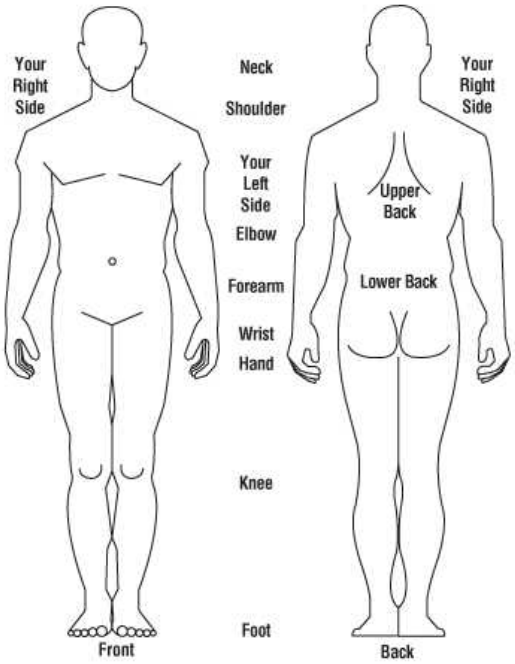
9. What improves this condition?

10. What do you believe is causing your most important health concerns?

11. How would you describe your general state of health?

- ○ Excellent
- ○ Good
- ○ Fair
- ○ Poor

12. Please indicate areas of concern:



13. Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? If 'yes', please list approximate dates.

14. Do you have any allergies (medicines, cosmetics, environmental, foods)? If 'yes', please describe.

15. Cardiovascular Please check the boxes for any condition(s) you have experienced or are experiencing:

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Stroke/CVA
- ☐ Phlebitis/varicose veins
- ☐ Heart disease
- ☐ Pacemaker or similar device(s)

16. Respiratory Please check the boxes for any condition(s) you have experienced or are experiencing:

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

17. **Bone Health**

History of Fractures? ○ Yes ○ No

If 'yes", please describe.

_____

18. **Diabetes**

○ Yes ○ No

If 'yes", please specify onset and type.

_____

19. **Epilepsy**

○ Yes ○ No

20. **Cancer**

○ Yes ○ No

If 'yes", please specify onset, type and current state.

_____

21. **Is there a family history of any of the above conditions? If 'yes', please describe.**

_____

_____

_____

_____

22. **Head / Neck Please check the boxes for any condition(s) you have experienced or are experiencing:**

- ☐ History of headaches
- ☐ History of migraines/ new onset?
- ☐ Vision loss/changes
- ☐ Dizziness/Double vision
- ☐ Hearing loss/ear condition(s)

23. **Other Condition(s) Please check the boxes for any condition(s) you have experienced or are experiencing:**

- ☐ Allergies/hypersensitivity?
- ☐ Mental health
- ☐ Digestive Conditions
- ☐ Organ dysfunction
- ☐ Other(s)

If "other(s)", please specify

_____

24. **Please list any previous surgical procedures and any details/hardware (i.e. prosthesis, wires, internal pins/fixators).**

_____

_____

_____

_____

25. **Please list the names and contact information of any other practitioners that are participating in your care, that you would like us to communicate with.**

26. **Habits and Lifestyle**

Do you smoke? ☐ Yes ☐ No	If 'yes', what?	How much per day?	Since when?
Do you drink alcohol? ☐ Yes ☐ No	If 'yes', what?	How much?	How often?
Do you drink soda pop? ☐ Yes ☐ No	If 'yes', what type? ○ Regular ○ Diet	How much?	How often?
Do you exercise regularly? ☐ Yes ☐ No	If 'yes', please describe what you do.		

27. **Current emotional stress scale:**

0 - No stress / 10 - Extremely stressed
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

28.

Height:	Current weight:	Ideal weight:
Your weight one year ago:	The most you have ever weighed?	When?

29. **Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics) and specify the date your started using it and dosage.**

	Medication	Date first use	Dosage
1			
2			
3			

30. **Anything else we should know about your health or Physical Therapy expectation?**

31. **How many day per week do you have practice/ games?**

32. Are you interested in learning more about injury prevention?

Signature

Date