9131 E Frontage Rd, Ste 1
Palmer, Alaska 99645

Recovery Waters
PHYSICAL THERAPY

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

General Patient Information

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: _____ Date of Birth: _____

What is your main complaint or problem? _____

_____

When did your problem begin? _____

Pain? ☐ No ☐ Yes (0-10, 10 most severe pain and location) _____

Smoke? ☐ No ☐ Yes (what and how much?): _____

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

Stress level 1-10? (LOW 1 – EXTREMELY HIGH 10) _____

Falls? ☐ No ☐ Yes (how often?): _____

Past Medical History		
Do you now or have you ever had:		
☐ Diabetes (type): _____	☐ Asthma	☐ Parkinson's Disease
☐ High Blood Pressure	☐ Epilepsy/Seizures	☐ Multiple Sclerosis
☐ Low Blood Pressure	☐ Cataracts/Glaucoma	☐ Traumatic Brain Injury
☐ Thyroid Problems	☐ Double Vision	☐ Anxiety
☐ Leukemia	☐ Macular Degeneration	☐ Depression
☐ Lung Problems	☐ Kidney Disease	☐ Psychiatric Illness
☐ Heart Problems	☐ Anemia	☐ Skin Disorder
☐ Auto-immune disease	☐ Hepatitis	☐ Blood Clots
☐ Stroke	☐ Osteoporosis	☐ Urinary Incontinence
☐ Scoliosis	☐ HIV/AIDS	☐ Currently Pregnant
☐ Rheumatoid Arthritis	☐ COPD	☐ Dizziness/Fainting
☐ Cancer (type):_____	☐ Respiratory Problems	☐ Other: _____
_____	☐ Pelvic Problems	_____

Past Surgical History (include date of surgery)	

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Medication List (Including Over the Counter)	
Name of Drug (dosage and frequency)	

Social		
Lives with: ☐ Alone ☐ _____	Stairs at Home: ☐ None ☐ Describe: _____	Working: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed ☐ Disability
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
☐ Lift Van	☐ Bedside Commode	☐ Single Point Cane
☐ Grab Bars in Shower	☐ Compression Stockings	☐ Quad Cane
☐ Grab Bars by Toilet	☐ Raised Toilet Seat	☐ Gait Belt

Have you received treatment for this condition by any of the following?		
☐ Medical Doctor	☐ Chiropractor	☐ Psychiatrist/Psychologist
☐ Osteopath	☐ Physical Therapist	☐ Counselor
☐ Dentist	☐ Occupational Therapist	☐ Massage Therapist
☐ Personal Trainer	☐ Speech Therapist	☐ Other: _____

Current Exercise: _____

Exercise Equipment Available to me: _____