Premier Health

Sports Medicine, Physical and Occupational Therapy Survey

Today's Date: _____ Name: _____

Preferred Name: _____ Date of birth: _____

Preferred Pronouns: ☐ She/Her ☐ He/Him ☐ They/Them

Communication Preference: ☐ Phone ☐ Text ☐ Both ☐ Neither

## Work History

As of today, do you have a job? ☐ Yes ☐ No

If yes, what is your job? _____ Is it? ☐ Full-time ☐ Part-time

What type of work do you do? ☐ Office Work ☐ Physical Labor

Is the activity: ☐ Light ☐ Medium ☐ Heavy Do you mainly: ☐ Sit ☐ Stand

List any hobbies or leisure activities you do to relax and have fun:

_____

## Referral Information

Why are you seeking therapy?

_____

If you had an injury, what was the cause? _____

Date of onset: _____ If you had surgery, the date of your surgery _____

Have you had therapy or seen a chiropractor for this issue? ☐ Yes ☐ No

If yes, how many visits? _____

## Safety Assessment

| In the last 3 months, have you: | Yes | No |
|---|---|---|
| Had any falls? | | |
| Been confused or feel mixed up? | | |
| Been impulsive or making hasty decisions? | | |
| Had problems moving around or walking? | | |
| Had problems with your balance? | | |
| Been lightheaded or dizzy? | | |
| Had feelings of tingling, numbness, pins, and needles? | | |
| Had a hard time getting up from a chair or the floor? | | |
| Do you use anything to help you get around, such as a walker, cane, or wheelchair? | | |



Please turn over to see page 2

| **Do you have any problems with your bowels?** | **Yes** | **No** |
|---|---|---|
| Do you have a sudden need to go or are not able to get to the bathroom in time? | | |
| Do you have any other problems? If yes, please write down what they are: | | |
| **Do you have any problems with your bladder?** | | |
| Do you have a sudden need to go or are not able to get to the bathroom in time? | | |
| Do you have any other problems? If yes, please write down what they are: | | |
| **Are you taking any of the following types of medicine to help you:** | **Yes** | **No** |
| Sleep | | |
| Calm down or relax, called a sedative | | |
| Lower your high blood pressure | | |
| Have bowel movements, called a laxative | | |
| Remove extra water from your body, called water pills | | |
| Relieve anxiety, called benzodiazepines, such as valium, Librium, and others | | |
| Stop or reduce seizures, called anti-epileptics | | |
| **Do you have any problems with your:** | **Yes** | **No** |
| Eyesight | | |
| Hearing | | |

Do you feel safe getting around in your home? ☐ Yes ☐ No If not, tell us why:

_____

Please list any injuries or surgeries you have had, such as severe sprains, fractures (broken bones), total hip or knee replacement, and others

_____

_____

## Nutrition

Have you lost or gained weight for no reason? ☐ Yes ☐ No If yes, tell us why:

_____

_____

## Special Requests

**Do you have any special requests or needs you would like us to know about, such as:**

How do you like to learn? ☐ Verbal ☐ Written ☐ Someone showing you how to do it

☐ Other ways you like to learn _____

☐ Cultural, values, or religious beliefs ☐ Emotional or memory needs

☐ Language needs ☐ Medical conditions ☐ Money concerns

☐ Other_____ ☐ No requests or needs

**Do you have any of the following? (check all the ones that you have or have had)**

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Diabetes | ☐ High blood pressure | ☐ Recent fracture |
| ☐ Arthritis | ☐ Drug/alcohol problems | ☐ Kidney disease | ☐ Seizure disorder |
| ☐ Asthma | ☐ Epilepsy | ☐ Metal implants | ☐ Skin problem |
| ☐ Bleeding problems | ☐ Fall risk | ☐ Multiple Sclerosis | ☐ Stroke |
| ☐ Cancer_____ | ☐ Heart attack | ☐ Osteoporosis | ☐ Thyroid problem |
| ☐ COPD | ☐ Heart disease | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Depression | ☐ Hepatitis | ☐ Pregnancy | |

☐ Limited range of motion, such as not able to lift your arms or reach very far, or others.

☐ Other _____

## Medicines

Have you ever been seen at a Premier Health facility? ☐ Yes ☐ No If you answered **no**, please list all the medicines you are now taking.

| Name of Medicine | Reason for Taking |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

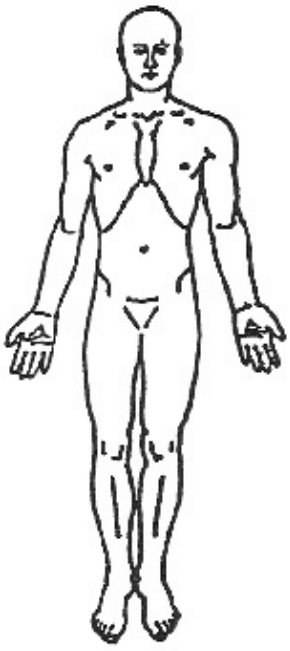
Do you have any allergies? ☐ Yes ☐ No If yes, tell us what they are:

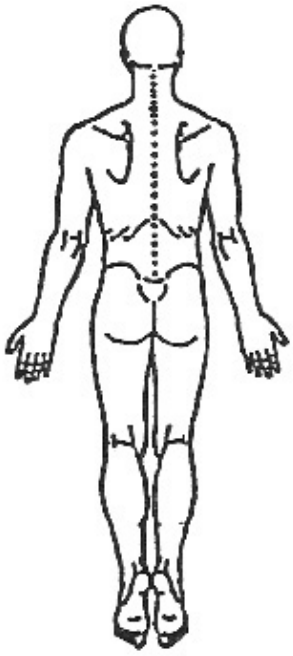
_____

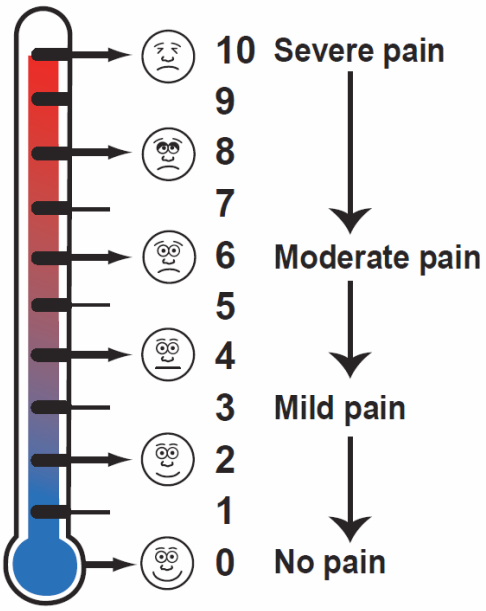
What do these allergies cause?

_____

Please turn over to see page 4








This scale was produced by the Northeast Health Care Quality Foundation with federal/QIO fundsand is reproduced with their permission.

**Please mark the areas of pain or problems you are having on the pictures above.**

**Rate your <u>current</u> pain level on the scale above by placing a circle around the number that best describes your pain.**

Please tell us what your pain feels like: (check all the ones that you have)

☐ Sharp ☐ Dull ☐ Aching ☐ Cramping ☐ Burning ☐ Throbbing

☐ Other: _____

How long does your pain last? ☐ Short time ☐ Comes and goes ☐ All the time

What makes your pain worse?

_____

What eases your pain?

_____

After your therapy treatments are finished, how low would you like your pain level to be? Please use the pain scale above to write down that pain level number _____ (0-10).