Premier Health

Sports Medicine, Physical and Occupational Therapy Survey

Today's Date: _____ Name: _____

Name you like to go by: _____ Date of birth: _____

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 did your doctor refer you to us for therapy?

_____

If you had an injury what was the cause? _____

Date of injury: _____ 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

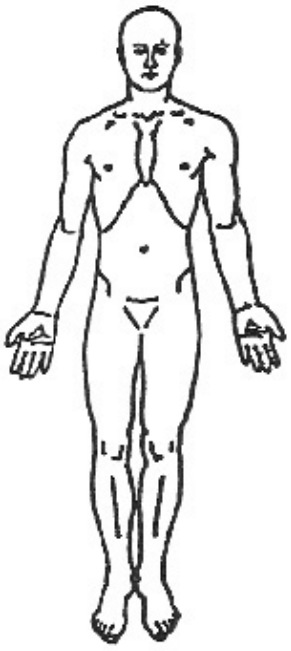
Do you have any allergies? ☐ Yes ☐ No If yes, tell us what they are:

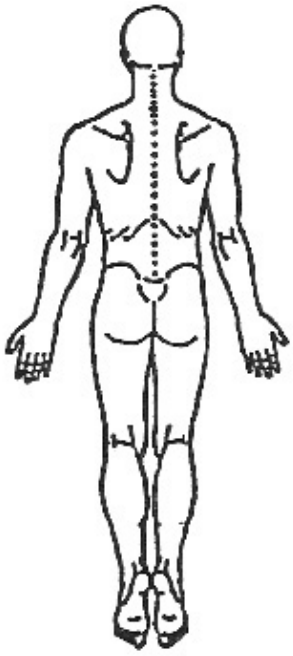
_____

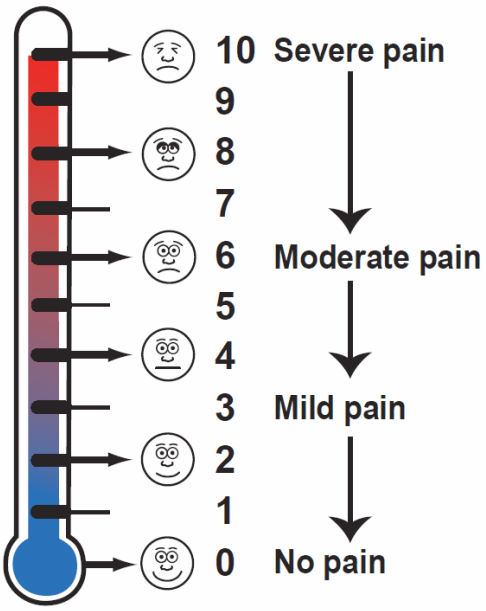
What do these allergies cause?

_____

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).

Premier Health