Glendale Adventist Medical Center
Adventist Health
1509 Wilson Terrace, Glendale, CA 91206

Date: ___/___/___ **Patient Name**: _____

Physical/Occupational/Speech Therapy Summary (75pts)

Do you have any known drug allergies? (nkda) ☐ Yes ☐ No If YES, please list drugs you are allergic to: _____
_____

Are you presently taking Medication? ☐ Yes ☐ No If YES, please list medications below and what you are taking them for.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list all major surgeries you have had and the year they were performed:

Type of Surgery	Date	Type of Surgery	Date

Have you had physical/occupational/speech therapy treatment within the last 60 days? ☐ No ☐ Yes

Have you been recently hospitalized? ☐ No ☐ Yes

History (75sr)

Age: ____ ☐ Male ☐ Female **Are you** ☐ right or ☐ left hand dominant? ☐ Ambidextrous?

Height: ____ ft ___inches Weight: _____ lbs **Are you satisfied with your weight?** ☐ Yes ☐ No

Date of injury or onset of present symptoms: ___ / ___ / ___ **Have you ever had these symptoms before?** ☐ Yes ☐ No

Check one or more of the following that apply to your present condition:

☐ Work related injury
☐ Motor vehicle accident
☐ Injury related to lifting
☐ Recurrence of previous injury
☐ Athletic / recreational injury
☐ Injury related to falling
☐ Have you been hospitalized in the last 3 months?
☐ Surgery (Specify): _____

What were you doing when you were injured or experienced the onset of your present condition and how did it happen?
_____
_____
_____
_____
_____
_____

Systems Review: Please check only the conditions you currently have

Constitutional
☐ Recent fevers/sweats
☐ Unexplained weight loss/gain
☐ Unexplained fatigue/weakness
☐ HIV
☐ Hepatitis A, B, or C
☐ Diabetes
☐ Cancer

Respiratory
☐ Cough/wheeze
☐ Coughing up blood
☐ Asthma

Skin
☐ Rash
☐ Sores
☐ MRSA

Eyes
☐ Change in vision
☐ Wear glasses

Gastrointestinal
☐ Blood or change in bowel movement
☐ Nausea/vomiting/diarrhea

Neurological
☐ Headaches
☐ Numbness
☐ Tremors
☐ Poor balance

Ears / Nose / Throat / Mouth
☐ Difficulty hearing/ringing in ears
☐ Hay fever/allergies/ ongestion
☐ Trouble swallowing

Endo
☐ Cold/heat intolerance
☐ Increased thirst/appetite

Blood / Lymphatic
☐ Unexplained lumps
☐ Easy bruising or bleeding

Genitourinary
☐ Painful/bloody urination
☐ Leaking urine
☐ Night time urination
☐ Discharge: penis or vagina
☐ Unusual vaginal bleeding
☐ Concern with sexual functions

Psychiatric
☐ Anxiety
☐ Sleep problem
☐ Depression

Cardiovascular
☐ Chest pains/discomfort
☐ Palpitations/irregular heartbeat
☐ Shortness of breath
☐ High Blood Pressure

Musculoskeletal
☐ Muscle/joint pain
☐ Recent back pain
☐ Weakness

Social Habits

Tobacco Use
Cigarettes: ☐ Never ☐ Quit: Date: _____ Current Smoker: Packs/day _____ # of years _____
Other Tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew
Are you interested in quitting? ☐ No ☐ Yes

Alcohol Use
Do you drink alcohol? ☐ No ☐ Yes - Number of drinks/week _____
Is your alcohol use a concern for you or others? ☐ No ☐ Yes

Drug Use
Do you use any recreational drugs? ☐ No ☐ Yes

Caffeine Intake: ☐ None ☐ Coffee/tea/soda_____cups/day

How many cups of water do you drink a day? _____

Past Medical History (75pmh)

Please only check the conditions that you had in the past

☐ Heart attack/Heart disease
☐ Irregular heart rate
☐ Chest pain
☐ High blood pressure
☐ Stomach/Intestinal problems
☐ Arthritis
☐ Substance abuse/Addiction
☐ Hernia
☐ Tested positive for HIV
☐ Allergies

☐ Bleeding/Bruise easily
☐ Emphysema
☐ Asthma/Breathing difficulties
☐ Thyroid problems
☐ Diabetes
☐ Depression
☐ Seizures
☐ Are you pregnant?
☐ Hepatitis A, B, or C
Other: _____

☐ Cancer
☐ Stroke
☐ Kidney problems
☐ Epilepsy/Seizures
☐ Allergy or poor tolerance to heat/cold
☐ Anxiety
☐ MRSA
☐ Osteoporosis
☐ Metal Implants

Family History

Has any of your immediate family had any of the following conditions?

☐ Heart Attack/Heart Disease	☐ Diabetes	☐ Cancer: (Type) _____
☐ Irregular Heart Rate	☐ Stroke	☐ Osteoporosis
☐ High Blood Pressure	☐ Asthma/Breathing Difficulties	☐ MRSA
☐ Arthritis	☐ Thyroid Problems	☐ Other: _____

Diagnostic Tests: (75dt)
Have you had an X-ray? ☐ Yes ☐ No **Have you had an MRI?** ☐ Yes ☐ No ☐ Other test:_____

If yes to any of the above please provide: Date of test: _____ Location of test: _____

Have you fallen within the last 12 months? ☐ Yes ☐ No **Did the fall result in an injury?** ☐ Yes ☐ No

Occupational History (75oh)

☐ Working full-time ☐ Working part-time ☐ On medical leave ☐ Disabled ☐ Retired ☐ Unemployed

What is your current occupation: _____

Where do you work? _____

What duties do you perform? _____

When did you last work? _____

How much do you have to lift at work? _____ lbs How long do you sit at a time at work? _____

How long do you have to stand? _____ Do you have any other work related requirements? _____

Learning / needs related to cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or memory limitation, or barriers to communication.

☐ None ☐ Environmental ☐ Perception ☐ Memory ☐ Emotional ☐ Financial ☐ Language ☐ Motivation

☐ Physical limitations ☐ Religious/cultural ☐ Other: _____

Home Environment Considerations

☐ Single level ☐ Multi-level ☐ Apartment/Condo ☐ Assisted Living ☐ Nursing Home ☐ Homeless

Are steps/stairs present at home? ☐ Yes ☐ No If YES do you have a railing? ☐ Yes ☐ No

Are you? ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Who do you live with? ☐ alone ☐ with spouse ☐ family ☐ care facility ☐ other _____

Do you have a care provider? ☐ Yes ☐ No ☐ Not Applicable

If yes, how much of the day are they available to you? ☐ 24 hrs/day ☐ 12 hrs/day ☐ 6 hrs/day ☐ 3 hrs/day ☐ other ____

Do you feel safe at home? (75sh) ☐ Yes ☐ No

Communication style or preferences: ☐ Demonstration ☐ Printed material ☐ Verbal instructions

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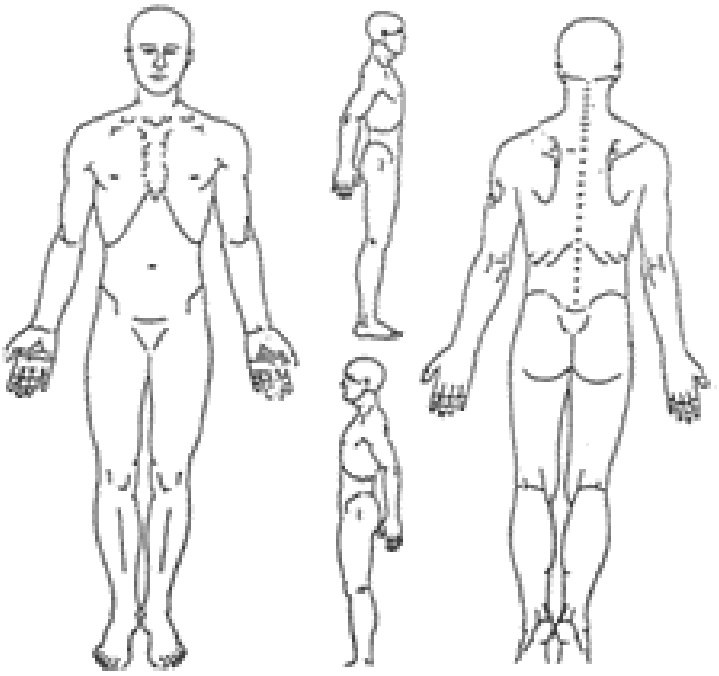
Pain

Mark your pain locations on the diagram



Pain Rating
Scale used 0-10 (0=no pain, 10=emergency room pain)

Please Circle Number
Pain at rest 0 1 2 3 4 5 6 7 8 9 10
Pain with activity 0 1 2 3 4 5 6 7 8 9 10

Description of Pain:
☐ Sharp ☐ Dull ☐ Burning ☐ Electrical ☐ Cramping
☐ Pain is localized ☐ Pain is radiating

What make your pain worse?
☐ Sitting ☐ Standing ☐ Walking ☐ Twisting

☐ Bending ☐Squatting ☐ Time of the day

☐ Running ☐ Climbing Stairs ☐ Physical Activity

☐ Weather ☐ Lifting floor to waist

☐ Lifting waist to over head ☐ Moving affected limb

☐ Sexual activity ☐ Lying Down ☐ Other: _____

What do you do to reduce your pain?

☐ Ice	☐ Walking	☐ Avoiding activity	☐ Exercise/PT	☐ Lying down
☐ Heat	☐ Massage	☐ Lose weight	☐ Medication	☐ Other
☐ Using Walker or Shopping Cart		☐ Resting more often	☐ Sitting More	

Does your pain affect your?

Sleep	☐ Yes	☐ No	Appetite	☐ Yes	☐ No
Physical activity	☐ Yes	☐ No	Emotions	☐ Yes	☐ No
Relationships	☐ Yes	☐ No	Concentration	☐ Yes	☐ No

What are your current functional limitations?

☐ Unable to work	☐ Difficulty bathing	☐ Difficulty dressing
☐ Difficulty with meal preparation	☐ Unable to drive	☐ Unable to shop
☐ Difficulty with walking	☐ Unable to perform usual hobbies	☐ Difficulty with steps
☐ Difficulty with bed mobility	☐ Reaching objects overhead	☐ Lifting
☐ Taking care of your children	☐ Other please specify: _____	

What are your goals in coming to therapy?

☐ Decrease pain	☐ Increase range of motion	☐ Increase strength
☐ Return to work	☐ Return to previous activities	☐ Be able to stand for _____
☐ Be able to sit for _____	☐ Other:_____	
☐ Other: _____		

Patient Signature _____ Date: _____