



8. Do you smoke or chew tobacco? Yes  
No

If yes, how many packs/pipes/pouches/sticks a day? \_\_\_\_\_

How many months or years? \_\_\_\_\_

9. I used to smoke/chew but I quit Yes  
No

If yes: pack or amount/day \_\_\_\_\_ Year quit \_\_\_\_\_

10. I would like to quit smoking/using tobacco Yes  
No

11. How much alcohol do you drink in the course of a week? (one drink is equal to 1 beer, 1 glass of wine or 1 shot of hard liquor) \_\_\_\_\_

12. Do you use recreational or street drugs (marijuana, cocaine, crack, meth, amphetamines, or others)? Yes  
No

If yes, what, how much, how often? \_\_\_\_\_

13. How much caffeine do you consume daily (including soft drinks, coffee, tea, or chocolate)? \_\_\_\_\_

14. Are you on any special diet? Yes  
No

15. Do you have (or have you recently had) any of these problems:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Blood in urine, stool, vomit, mucous swallowing/speaking             | <input type="checkbox"/> Cough                            | <input type="checkbox"/> Difficulty       |
| <input type="checkbox"/> Dizziness, fainting, blackouts                                       | <input type="checkbox"/> Dribbling or leaking urine       | <input type="checkbox"/> Memory loss      |
| <input type="checkbox"/> Fever, chills, sweats (day or night)                                 | <input type="checkbox"/> Heart palpitations or fluttering | <input type="checkbox"/> Confusion        |
| <input type="checkbox"/> Nausea, vomiting, loss of appetite weakness                          | <input type="checkbox"/> Numbness or tingling             | <input type="checkbox"/> Sudden           |
| <input type="checkbox"/> Changes in bowel or bladder  | <input type="checkbox"/> Swelling or lumps anywhere       | <input type="checkbox"/> Trouble sleeping |
| <input type="checkbox"/> Throbbing sensation/pain in belly or anywhere else seeing or hearing |   | <input type="checkbox"/> Problems         |
| <input type="checkbox"/> Skin rash or other changes   | <input type="checkbox"/> Unusual fatigue, drowsiness      | <input type="checkbox"/> None of these    |

**Past Medical History**

Have you or any immediate family member (parent, sibling, child) ever been told you have:

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Circle one:			Self or Family Member	Date of Onset	Current Status
• Allergies	Yes	No			
• Angina or chest pain	Yes	No			
• Anxiety/Panic attacks	Yes	No			
• Arthritis	Yes	No			
• Asthma, hay fever, or other breathing problems	Yes	No			
• Cancer	Yes	No			
• Chemical dependency (alcohol/drugs)	Yes	No			
• Cirrhosis/liver disease	Yes	No			
• Depression	Yes	No			
• Diabetes	Yes	No			
• Tuberculosis	Yes	No			
• Eating disorder (bulimia, anorexia)	Yes	No			
• Headaches	Yes	No			
• Heart attack	Yes	No			
• Hemophilia/slow healing	Yes	No			
• High cholesterol	Yes	No			
• Hypertension or high blood pressure	Yes	No			
• Kidney disease/stones	Yes	No			
• Multiple sclerosis	Yes	No			
• Osteoporosis					
• Stroke	Yes	No			
• Other (please describe)	Yes	No			

## Personal History

Have you ever had:

- |   |     |    |
|---|-----|----|
| • Anemia  | Yes | No |
| • Shortness of breath                                   | Yes | No |
| • Skin problems   | Yes | No |
| • Pneumonia   | Yes | No |
| • Rheumatic/scarlet fever                               | Yes | No |
| • Prostate problems                                     | Yes | No |
| • Urinary incontinence problems<br>(dribbling, leaking) | Yes | No |
| • Thyroid problems                                      | Yes | No |
| • Urinary tract infection                               | Yes | No |
| • Ulcer/stomach   | Yes | No |
| • Varicose veins  | Yes | No |
| • Chronic bronchitis                                    | Yes | No |
| • Epilepsy/seizures                                     | Yes | No |
| • Emphysema   | Yes | No |
| • Fibromyalgia/myofascial pain                          | Yes | No |
| • GERD syndrome   | Yes | No |
| • Gout  | Yes | No |
| • Hepatitis/jaundice                                    | Yes | No |
| • Guillain-Barré Syndrome                               | Yes | No |
| • Hypoglycemia  | Yes | No |
| • Joint replacement                                     | Yes | No |
| • Parkinson's disease                                   | Yes | No |
| • Polio/postpolio                                       | Yes | No |
| • Peripheral vascular disease                           | Yes | No |



**Work/Living Environment**

1. What is your job or occupation?

2. Military service: (When and where):

3. Does your work involve:
- Prolonged sitting (e.g., desk, computer, driving)
  - Prolonged standing (e.g., equipment operator, sale clerk)
  - Prolonged walking (e.g., mill worker, delivery service)
  - Use of large or small equipment (e.g., telephone, forklift, computer, drill press, cash register)
  - Lifting, bending, twisting, climbing, turning
  - Exposure to chemicals, pesticides, toxins, or gases
  - Other: please describe
  - Not applicable; none of these

4. Do you use any special supports:
- Back cushion, neck cushion
  - Back brace, corset
  - Other kind of brace or support for any body part
  - None; not applicable

**History of falls:**

- In the past year, I have had no falls.
- I have just started to lose my balance/fall.
- I fall occasionally.
- I fall frequently (more than two times during the past 6 months).
- Certain factors make me cautious (e.g., curbs, ice, stairs, getting in and out of the tub).

**I live:**

- Alone
- With family, spouse, partner
- Nursing home
- Assisted Living
- Other \_\_\_\_\_

**For the physical therapist:**

*Vital Signs*

Resting pulse rate:

Oral temperature:

Respirations:

Oxygen saturation:

Blood pressure: 1<sup>st</sup> reading \_\_\_\_\_ 2<sup>nd</sup> reading \_\_\_\_\_

Position: Sitting      Standing

Extremity: Right      Left

