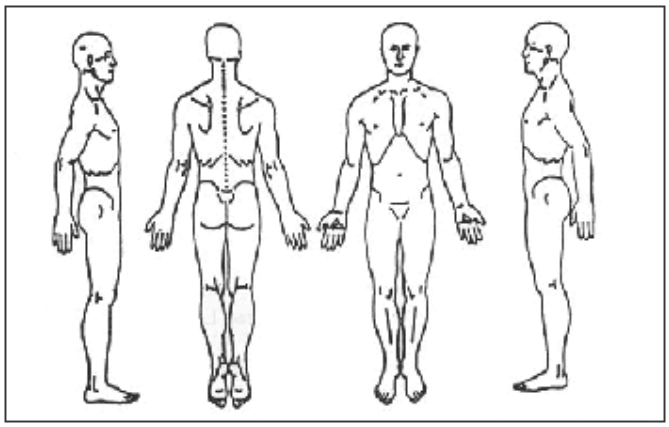
PHYSICAL THERAPY
at Walmart Health with HPRC

Name:	Date:	Gender:	DOB:

CURRENT INJURY: _____

Please mark below where your pain is located



Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Date started?
Describe the onset and history of current condition _____ _____
Occupation?
□ Full Time □ Retired □ Not employed □ Part Time □ Disabled □ Modified □ Full or Part Time Student

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

□ Osteoporosis	□ High cholesterol	□ Difficulty emptying bladder
□ Osteoarthritis	□ High blood pressure	□ Kidney stones
□ Rheumatoid arthritis	□ Asthma	□ Painful intercourse
□ Dizziness	□ COPD/ Emphysema	□ Sexually transmitted disease
□ Clumsiness or staggering	□ Palpitations	□ Numbness
□ Double vision	□ Heart disease	□ Taste or smell change
□ Falls to the ground	□ Heart attack	□ Skin turning yellow color
□ Fatigue	□ Wheezing/ Coughing	□ Rash/Itching or scaly patches
□ Difficulty speaking	□ Difficulty swallowing	□ Hair or nail changes
□ Fever or chills	□ Abdominal pain or fullness	□ Swelling in the arms or legs
□ Night pain or sweats	□ Constipation	□ Liver or gallbladder Issues
□ Muscle cramps	□ Heartburn	□ Thyroid problems
□ Blood clots	□ Vomiting/ Nausea	□ TB □ Current □ Past
□ Diabetes	□ Appetite or weight change	□ Allergies
□ Open sores or wounds	□ Change in bowel habits	**Females:**
□ Dark red/purplish legs	□ Blood in stool or urine	□ Currently Pregnant
□ Fibromyalgia	□ Incontinence	□ Regular Menstrual Cycle
□ Anxiety □ Depression	□ Low urine output	□ Menopausal Symptoms
□ Abuse □ Neglect	□ Urinary infection	□

Have you had any of the following procedures?

□ Bypass Surgery	□ Pacemaker	□ Joint Replacement
□ Cardiac Ablation	□ Stent Placement	□ Metal Implants

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Mental Health Background:
*Over the last 2 weeks, have you had thoughts that you would be better off dead? □ Yes □ No

IF NO to the above question, no need to answer 1&2 below. **IF YES** please answer 1&2 below questions:
1. Have you wished you were dead or wished you could go to sleep and not wake up? □Yes □No
2. Have you actually had any thoughts of killing yourself? □Yes □No

Falls:
Have you fallen in the past yr.? □ Yes □ No If so, how many times? _____ Injured? □ Yes □ No

Please list your current medications, vitamins and supplements. *(If your medications are written down, please allow us to scan into your chart)* ***Please specify blood thinners and NSAID's***

_____

_____

_____

Please list any major surgeries (past 5 years) ***or pertinent to current condition***

_____

_____

Please list any diagnostic tests you've had performed ***specific to current condition***

□ Biopsy
□ Blood work/Lab Tests
□ Bone Density Scan
□ CT Scan
□ EEG
□ EMG
□ Lower GI Study
□ Motility Study
□ MRI
□ Nerve Conduction Study
□ Swallow Study
□ Upper Endoscopy
□ Ultrasound
□ X-Ray
□ Other

Living Situation

□ Single Story Home
□ 2 Story Home
□ Ground Floor Apartment
□ Upper Level Apartment
□ Assisted Living Facility
□ Skilled Nursing Facility
Are there stairs at home? □ Yes □ No Is there a handrail present? □ Yes □ No

Who do you live with?

□ Spouse
□ Spouse + Children
□ Child(ren)
□ Other Family Member
□ Alone
□ Other
Are others available to help if needed? □ Yes □ No

What is your primary role at home?

□ Caregiver for others
□ Financial Provider
□ Housework
□ Home Maintenance
□ Yard Maintenance
□ Other
Are you currently able to perform these roles? □ Yes □ No

Social Habits:

Smoker/Tobacco Products?	Current/Past Usage per Day?	Year stopped?
Coffee? Y / N Drinks/week?	Alcohol? Y / N Drinks/week?	Soft Drinks? Y / N Drinks/week?
Current or Prior Exercise Program?		Frequency/Duration?