OSPTI Health Form: Name:_____________________________ Date: ________

1. What is your work status? (circle answer and if not employed, skip to question 5)
a. Employed **b.** Unemployed **c.** Student **d.** Retired **e.** Homemaker **f.** Disabled

2. Who/what is your employer and occupation? ______________________________________

3. If employed, are you working:
a. without restrictions **b.** with restrictions **c.** working an alternate job **d.** not working

4. What are your primary job tasks? (circle those that apply)
a. sitting **b.** standing **c.** repetitive tasks **d.** operating a machine/driving **e.** lifting

5. Do you use tobacco? Yes___No____ If so, How Much?________ What Kind?________

6. For what pain/problem(s) are you seeking services for? ___________________________________

7. On a scale of 1-10 (1 being good and 10 being very painful), rate your pain ______________________

8. When did this problem begin? (date) ____________________

9. Where/when did the pain/injury occur?
a. work **c.** in a motor vehicle **e.** during competitive sports **g**. other:________
b. at home **d.** during recreation **f.** for unknown reasons

10. Current symptom description (circle those that apply):
constant intermittent pain achy burning dizziness numb tingling other

11. What affects your pain (please check)?

	Better	Worse	Same		Better	Worse	Same
Ice				Morning			
Heat				Late Afternoon			
Position Changes				Night/Sleep/Rest			
Coughing/Sneezing				With Activity			

12. Have you had any prior treatment for this problem?

	When:	Was it Helpful?	
a. None	_________________	Yes No	
b. Therapy-PT, OT, ST	_________________	Yes No	
c. Chiropractor	_________________	Yes No	
d. Medications/Injections	_________________	Yes No	
e. Surgery	_________________	Yes No	Surgeon: ___________________
f. Other ____________________	_________________	Yes No	

13. Have you had this problem before? Yes No If yes, when:____________

14. Have you ever had any special test for this problem?
a. None **b.** X-ray **c.** CT scan **d.** MRI **e.** EMG **f.** other ____________________

15. Test results: ____

16. How did you hear about OSPTI:
a. Dr Referral **b.** Self Referral **c.** Radio Ad **d.** Website **e.** Facebook **f.** Town Event
g. Past Patient: ____________ **h.** Friend:________________ **i.** other:______________

Turn over to complete the form.

For internal office use only:
Height: _____________ Weight:______________ BMI: ______________
Given information folder on exercise benefits and IEP: yes____

Medical History

Existing or Relevant Previous Conditions

Condition		Condition		Condition	
Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Body Region: ______________________ Surgery Type: ________________________ Date: ______________, _______, __________

Current Medications

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

Drug: _______________ Dosage: _______ Frequency: ___________ Route: ___________ Reason Taking: ______________________

☐ **Currently not taking any medications**