

Premier Health

Sports Medicine, Physical and Occupational Therapy Survey

Today's Date: _____ Name: _____

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

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 _____

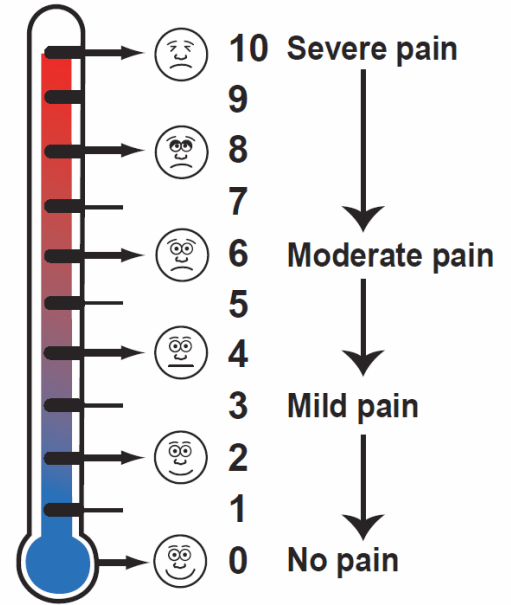
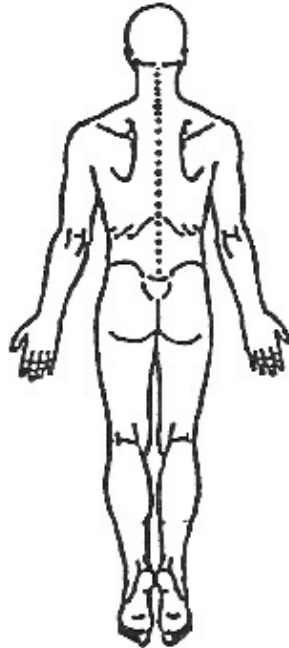
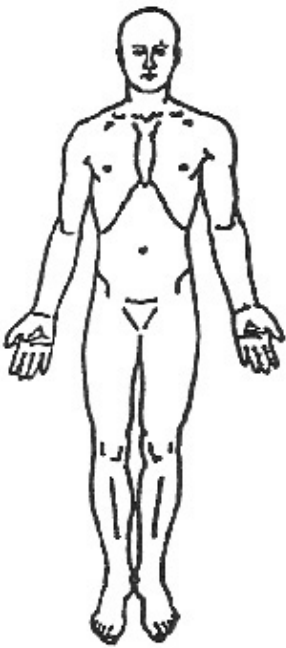
Medicines

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?



This scale was produced by the Northeast Health Care Quality Foundation with federal/QIO funds and is reproduced with their permission.

Please mark the areas of pain or problems you are having on the pictures above.

Rate your current 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).

