Balanced Body
Client Information

Date_____

Name_____**SS#**_____

Address _____**City**_____ **State**___ **Zip**_____

Home Ph_____ **Work** _____**Cell**_____

D.O.B._____ **Age**_____ **Marital Status**_____

Occupation (current/former)_____

Employer/Business/Practice _____

Student: Yes No Full Part-time Enrolled at_____

Name of Spouse/ Nearest Relative_____ **Ph**_____

Emergency Contact (If different from above) _____ **Ph**_____

How did you hear about us?

I'm a former client___ **My physician** _____
(name)

Radio___ **Newspaper**___ **Both**___ **Friend or Relative**_____

Other Health Professional ___ (PT, Massage Therapist) _____
(name)

Internet___ **Phone Book**___ **Other**_____

Email_____
(WE WILL USE ONLY IF WE CAN'T REACH YOU ANY OTHER WAY)

BALANCED BODY PHYSICAL THERAPY AND PILATES

Client Health Questionnaire
Part I

Name _____ Date _____

Male ( ) Female ( ) D.O.B. _____ Age _____ Cultural Heritage (Optional) _____

Height _____ Weight _____ Has your height or weight changed in recent months/years? _____

If you have any special needs to be considered prior to or during treatment or training, please describe below:

_____

_____

Overall physical condition: Poor _____ Fair _____ Good _____ Excellent _____ Smoker? yes ❑ no ❑

Major life changes in past year: (new job, baby, death in family, divorce, child leaving home, retirement)

_____

Health habits: Exercise beyond normal daily activities and chores? No ❑ Yes ❑ Describe the exercise, including how often, how long _____

_____

Medical History: Check or circle those that apply to you now or in the past.

___ Asthma
___ Emphysema/COPD
___ Congestive Heart Failure
___ Hypertension
___ Angina
___ Mitral Valve Prolapse
___ Atrial Fibrillation
___ Other Arrhythmia
___ Pacemaker
___ Other Heart Problems
___ Aneurysm
___ Blood Clots/Phlebitis
___ Stroke/TIA
___ Other Circulation Disorders
___ Seizures/Epilepsy
___ Essential Tremor
___ Headaches/Migraines
___ Parkinson's
___ Other Neurological Disorders
___ Thyroid Problems

___ Diabetes
___ Cancer
Type _____
___ Chemotherapy
___ Blood Disorders
___ Anemia
___ Neutropenia
___ Kidney/Adrenal Disorders
___ Dialysis
___ Urinary/Bladder Control Problems
___ Organ Transplant
___ Autoimmune Disorder
___ Immune Disorder
___ Crohn's Disease
___ Eating Disorder
___ Gastric Bypass
___ Ulcerative Colitis
___ Other Digestive Disease

___ Psoriasis
___ Impetigo
___ Poison Ivy/Oak
___ Eczema
___ Other Rashes or Skin Problems
___ Depression
___ Anxiety
___ Bipolar Disorder
___ Other Psych/Emotional Problem
___ Chronic Pain or other Pain Syndromes
___ Vision Problems
___ Hearing Problems

Have you ever had, have you recently been exposed to, or currently have:
___ Chicken Pox
___ Measles
___ Encephalitis

___ Polio
___ Herpes
___ Shingles
___ Hepatitis B
___ Hepatitis C
___ Hepatitis A
___ TB or positive TB skin test
___ HIV/AIDS
___ Flu
___ Pertussis (whooping cough)

Have you received any of the following immunizations/ when?
___ Flu (annual)
___ Tetanus/Diptheria (every 10 years)
___ Chicken Pox or new Shingles vaccine
___ Hepatitis B
___ Pneumococcal Vaccine

Explain any problems you have checked above: _____

_____

_____

_____

_____

Do you take any of the following types of Medications: __Anti-Rejection __Chemo __Steroids __Blood-thinners __Rheumatoid Arthritis Drugs? _____ Please describe _____

_____

Check any current symptoms:

___Chest Pain
___Shortness of Breath
___Heart Palpitations
___Fatigue
___Ankle Swelling
___Dizziness
___Coordination Problems
___Loss of Balance

___Difficulty Walking
___Numbness/Tingling
Where?_____
___Weakness
___Arms
___Legs
___Abdominal Pain
___Fever/Night Sweats

___Difficulty Sleeping
___Cough
___Hoarseness
___Difficulty Swallowing
___Muscle Pain?
Where?_____
___Sprain
Where?_____

___Joint Pain
Where?_____
___Other pain?
Where?_____
___Limited Movement
Where?_____
___Night Pain
Where?_____

Orthopedic/Neuromuscular Disorders
___ Osteoarthritis
___ Rhematoid Arthritis
___ Tendonitis
___ Bursitis
___ Shoulder/Rotator Cuff
___ Back Problems
___ Carpal Tunnel Syndrome

___ Sciatic Nerve Pain
___ Peripheral Neuropathy
___ Spinal Fusion
___ Vertebroplasty
___ Spinal Stenosis
___ Scoliosis
___ Knee Problems
___ Knee Replacement
___ Hip Problems
___ Hip Replacement

___ Fractured Hip
___ Neck Injury
___ Other Fractures
___ Sprains/Strains
___ Spondylolisthesis
___ Fibromyalgia
___ Osteopenia
___ Osteoporosis
___ Stroke
___ Head Injury

___ Spinal Cord Injury/ Paralysis
___ Parkinson's
___ Multiple Sclerosis
___ Post Polio Syndrome
Other _____
_____
_____
_____

Tell us about any of the above neuromuscular and orthopedic problems. List and give approximate year of any injuries, treatments, surgery, hospitalizations, rehab, medication or physical therapy you received:

_____
_____
_____
_____
_____
_____

List current medications: _____
_____
_____

For Women Only: Are you pregnant?_____ Date of last delivery?_____ # of pregnancies _____

# of vaginal deliveries _____ # of C-sections? _____ perimenopausal? _____ menopausal? _____

Within the past year, have you had any of the following medical tests? (check all that apply)

❑ Angiogram
❑ MRI
❑ Biopsy (describe) _____
❑ Blood Tests
❑ Bone Scan
❑ Bronchoscopy
❑ Pulmonary Function Tests
❑ CT Scan
❑ EKG
❑ Cardiac Stress Test
❑ Myelogram
❑ Nerve Conduction Velocity
❑ Electromyogram
❑ Arthroscopy
❑ EEG
❑ Bone Density Test
❑ Urine Flow Studies
❑ Cystoscopy
❑ Pap Smear
❑ Mammogram

If other than routine test, please explain: _____
_____
_____

Is there any health-related reason why you should not participate in an exercise program? _____
_____

What would you like to get out of our physical therapy or wellness program?_____
_____
_____

BALANCED BODY PHYSICAL THERAPY AND PILATES

Client Health Questionnaire
PART II

NAME: _____

What is your primary problem? _____

_____

When/how did it begin? _____

_____

Have you had this problem before? _____ If so, when? _____

What did you do for it? _____

_____

Did the problem(s) get better? _____ How long did it last? _____

What treatments/diagnostic tests have you received for this problem?

___None ___Surgery ___injections ___Splint/Brace ___X-rays ___MRI ___CT Scan

___Chiropractic Care ___Massage Therapy ___Physical Therapy

___Medications (prescription and nonprescription) _____

_____

___Other _____

How are you managing the problem now? _____

_____

What activities are you not able to do that you could do before the problem (be as specific as you can.)

(Example: unable to reach above your head.) _____

_____

What makes the problem worse? _____

_____

What makes the problem better? _____

_____

When are your symptoms most severe? ___AM ___PM ___Consistent all day

Since your problem began is the pain: ___ Increased ___ Decreased ___ Not Changing ___ Constant ___Intermittent

Rate your pain with 0 being no pain and 10 being the worst pain:

Pain now 0 1 2 3 4 5 6 7 8 9 10 Best day 0 1 2 3 4 5 6 7 8 9 10 Worst day 0 1 2 3 4 5 6 7 8 9 10

Do you have any other significant problems? _____

_____

_____

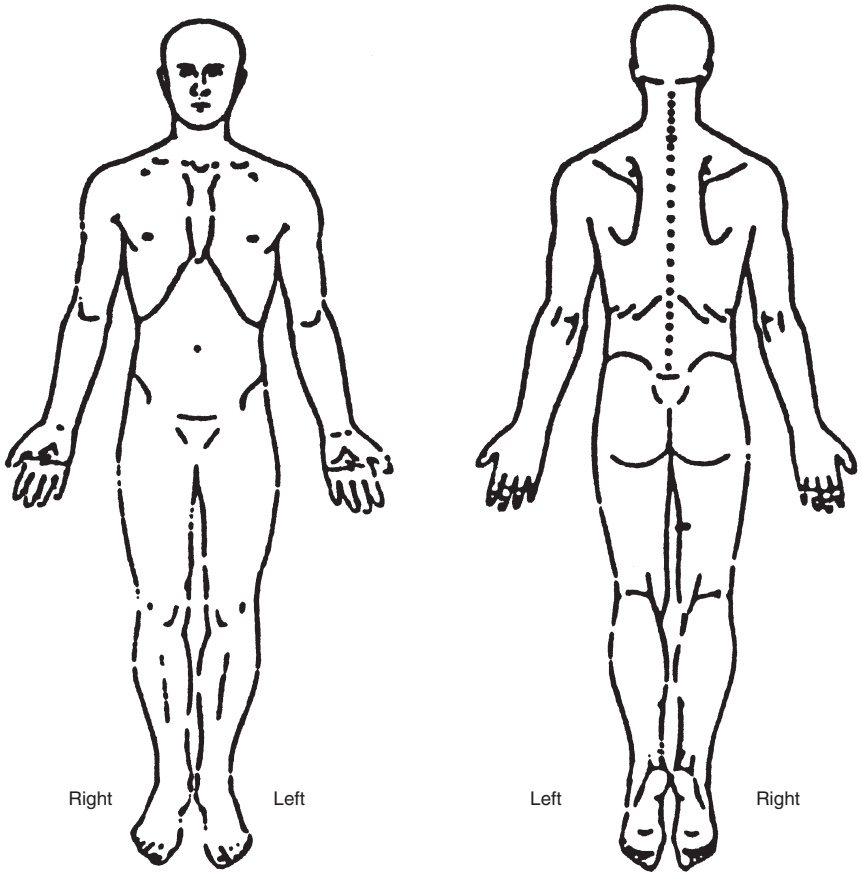
Your goal in therapy: What concerns you most? What do you hope to gain from this program?

_____

_____

_____

Using the following pictures, indicate where your pain is located. Using these symbols describe your type of pain:
Numbness === Ache ^^^ Pins/needles 0000 Stabbing ///// Burning XXXX Cramping ++++ Sharp ****



Are your symptoms affecting your ability to work or otherwise be active ___ If so, how?

_____

_____

Current Limitations: (check all that apply):

❑ Difficulty with movement ❑ Getting in/out of bed or up/down from a chair

❑ Changing positions in bed ❑ Difficulty with grooming and bathing

❑ Walking: ❑ level ❑ stairs ❑ ramps ❑ uneven terrain

❑ Difficulty with home management (household chores, yard work, driving, shopping): _____

_____

❑ Difficulty with community and work activities (work, school, play, recreation): _____

_____

Thank you for taking the time to provide this information.
Balanced Body Staff

OPTIMAL INSTRUMENT

PATIENT'S NAME_____ **DATE** _____

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking-short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about <u>*all*</u> of the activities you would like to do, please mark an "X" at the point on the line that best describes your <u>*overall*</u> level of difficulty with these activities today.

I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1.* <u>*12*</u> *2.* <u>*8*</u> *3.* <u>*13*</u>)
1. _____ **2.** _____ **3.** _____

For Therapist Use: Total Score _____ **-** # of questions answered _____ = _____% disability _____
84 (for 21); 80 (for 20); 76 (for 19); 72 (for 18)

_____P.T.

Patient Name: _____

Medication List

Balanced Body

Prescription Medication

Over the Counter Medications that you regularly take (baby aspirin, ibuprofen, Tylenol, antihistamines, medication for reflux, etc.)**:**

Vitamins, Nutritional Supplements, Herbal Products, Probiotics:
