9061 E Frontage Rd
Palmer, Alaska 99645

Recovery Waters
PHYSICAL THERAPY

Phone: 907-795-4255
Fax: 907-802-6559

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you.

Name: ____

What is your complaint or problem? ____

When did your problem begin? ____

What to you hope to achieve with PT? ____

Height: ______________ Weight: _________________

Pain? ☐ No ☐ Yes (**If yes,** where and intensity 0-10, 0 no pain - 10 most severe pain)____________________
____

Allergies? ☐ No ☐ Yes (to what?): ____

Any falls over last 12 months? ☐ No ☐ Yes (how often?): ______________________________________

Past Medical History		
Do you ***now or have you ever had***:		
☐ Diabetes (type): ______	☐ Epilepsy/Seizures	☐ Scoliosis
☐ High Blood Pressure	☐ Double Vision	☐ Parkinson's Disease
☐ Low Blood Pressure	☐ Macular Degeneration	☐ Multiple Sclerosis
☐ **Congestive Heart Failure/cardiac edema**	☐ Vision Impairments	☐ Traumatic Brain Injury
	☐ Hard of hearing	☐ Stroke/TIA
☐ Heart Attack	☐ Hepatitis	☐ Anxiety
☐ Varicose veins	☐ Liver disease	☐ Depression
☐ Venous Insufficiency	☐ HIV/AIDS	☐ Bipolar
☐ Hypothyroidism	☐ Asthma	☐ Schizophrenia
☐ Hyperthroidism	☐ COPD	☐ Psychiatric Illness
☐ **Kidney Failure**	☐ Cellulitis	☐ Dementia/Alzheimer's
☐ Auto-immune disease	☐ Active infection	☐ Asperger's/Autism
☐ Migraines	☐ Abdominal aortic aneurysm	☐ Skin Disorder
☐ Back pain		☐ Blood Clots
☐ Osteoporosis	☐ Diverticulitis	☐ Ehlers-Danlos Syndrome
☐ Osteoarthritis	☐ **Severe arteriosclerosis (ABI 0.49 or less)**	☐ Urinary Incontinence
☐ Rheumatoid Arthritis		☐ Currently Pregnant
☐ Fibromyalgia	☐ Inflammatory bowel	☐ Breast Feeding
☐ Altered sensation	☐ Chrohn's disease	☐ Dizziness/Fainting
☐ Wound(s)	☐ Ulcerative colitis	☐ Other: ______________
☐ Latex Allergy	☐ Bruise easily	____________________________
☐ Cancer (type):_________	☐ Hyper-flexibility	____________________________
______________________		

frontdesk@recoverywaterspt.com

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Past Surgical History (include date of surgery)	

Medication List (Including Over the Counter)	
(Please list name of drug, dosage, and frequency)	

Social		
Lives with: ☐ Alone ☐ ______________________	Stairs at Home: ☐ None ☐ # of stairs: ___________	Daily Task: ☐ Cooking ☐ Cleaning ☐ Pet care ☐ Childcare ☐ Working a job ☐ Yard work ☐ Snow removal
Occupation:		
Physical Demands Required for Job:		

Equipment at Home		
☐ Manual Wheelchair	☐ Shower Chair/Bench	☐ Hospital Bed
☐ Electric Wheelchair	☐ Reacher	☐ Standard Walker
☐ Scooter	☐ Bedrails	☐ Walker with Seat
☐ Grab Bars in Shower	☐ Bedside Commode	☐ Single Point Cane
☐ Grab Bars by Toilet	☐ Compression Hose	☐ Quad Cane
☐ Raised Toilet Seat	☐ Compression Wraps	☐ Gait Belt

Current Exercise: ____

Exercise Equipment Available to me: ____