|  |
| --- |
| **Demographics** |
| **Name:** Click here. | **Date form completed:** Click or tap to enter a date. |
| **Address:** Click here. | **City:** Click here. | **State:** \_\_ | **Zip:** Click here. |
| **Phone number:** Click here | **Email address:** Click here |
| **Date of birth:** Click here. | **Age:** Click here. years | **Sex** (assigned at birth)**:** | [ ]  Female | [ ]  Male |
| **Gender identity:**[ ]  Female [ ]  Transgender[ ]  Male [ ]  Trans-female[ ]  Trans-male [ ]  Other[ ]  Nonbinary/gender-nonconforming[ ]  Prefer not to say | **Sexual orientation:**[ ]  Straight/heterosexual[ ]  Gay or lesbian[ ]  Bisexual[ ]  Other[ ]  Prefer not to say |
| **Ethnicity/race:**[ ]  Hispanic, Latino, or Spanish[ ]  Black or African American[ ]  American Indian or Alaska Native[ ]  Chinese, Filipino, Asian Indian, Vietnamese, Korean, Japanese, or other Asian | [ ]  White[ ]  Native Hawaiian, Samoan, Chamorro, or other Pacific Islander[ ]  Prefer to self-describe: Click here.[ ]  Prefer not to say |
| **Education Level** (highest grade completed)**:**[ ]  K-12[ ]  Some college / technical school[ ]  College graduate[ ]  Graduate school / advanced degree | **Occupation/employment status:**[ ]  Retired[ ]  Full-time[ ]  Part-time[ ]  Unemployed |
| **Enough food to eat:** [ ]  Yes [ ]  No | **Adequate housing:** [ ]  Yes [ ]  No |
| **Access to health care:** [ ]  Insured [ ]  Underinsured [ ]  Uninsured |
| **Preferred/primary language:** | Click here to enter text. |
| **Primary care health care provider:** | Click here to enter text. |
| **Other relevant health care provider(s):** | Click here to enter text. |
| **Are you currently seeing a physical therapist?** | Click here to enter text. |
| **Have you seen a physical therapist in the last year?** | Click here to enter text. |
| **Emergency contact name:** Click here to enter text. | **Phone number:** Click here to enter text. |

# Patient and Client Health and Wellness Goals

|  |
| --- |
| **Relevant Medical History** |
| **Current Medications:** |  |  |
| **Have you been advised by a medical provider not to exercise?** | [ ]  Yes [ ]  No |  |
| **Height:** Click here. feet Click here. inches | **Weight:** | Click here. lbs. |
| **Do you have any of the following medical conditions?** | **Comments:** |
| High blood pressure (BP)/hypertension | [ ]  Yes [ ]  No | What is your usual BP: Click here to enter text. |
| Heart attack | [ ]  Yes [ ]  No | Click here to enter text. |
| Heart surgery, cardiac catheterization, or coronary angioplasty | [ ]  Yes [ ]  No | Click here to enter text. |
| Pacemaker, implantable cardiac defibrillator, rhythm disturbance | [ ]  Yes [ ]  No | Click here to enter text. |
| Heart valve disease | [ ]  Yes [ ]  No | Click here to enter text. |
| Heart failure | [ ]  Yes [ ]  No | Click here to enter text. |
| Heart transplant | [ ]  Yes [ ]  No | Click here to enter text. |
| Congenital heart disease | [ ]  Yes [ ]  No | Click here to enter text. |
| Blood disorders (anemia) | [ ]  Yes [ ]  No | Click here to enter text. |
| Diabetes or high blood sugar | [ ]  Yes [ ]  No | Click here to enter text. |
| Hypoglycemia or low blood sugar | [ ]  Yes [ ]  No | Click here to enter text. |
| Kidney/urinary problems (urgency, leakage) | [ ]  Yes [ ]  No | Click here to enter text. |
| Arthritis (osteoarthritis, rheumatoid arthritis) | [ ]  Yes [ ]  No | Click here to enter text. |
| Osteoporosis or bone fractures | [ ]  Yes [ ]  No | Click here to enter text. |
| Musculoskeletal problems | [ ]  Yes [ ]  No | Click here to enter text. |
| Lung Problems (COPD, asthma, shortness of breath) | [ ]  Yes [ ]  No | Click here to enter text. |
| Depression | [ ]  Yes [ ]  No | Click here to enter text. |
| Neurologic diseases (Parkinson disease, multiple sclerosis, stroke) | [ ]  Yes [ ]  No | Click here to enter text. |
| Head injury | [ ]  Yes [ ]  No | Click here to enter text. |
| Seizures, epilepsy | [ ]  Yes [ ]  No | Click here to enter text. |
| Cancer of any type | [ ]  Yes [ ]  No | Click here to enter text. |
| Thyroid problems | [ ]  Yes [ ]  No | Click here to enter text. |
| Stomach problems, ulcers | [ ]  Yes [ ]  No | Click here to enter text. |
| Bowel problems (constipation, gas/stool leakage) | [ ]  Yes [ ]  No | Click here to enter text. |
| Chronic pain | [ ]  Yes [ ]  No | Click here to enter text. |
| Altered sensation in hands, legs, feet | [ ]  Yes [ ]  No | Click here to enter text. |
| Wounds/ulcers/skin diseases | [ ]  Yes [ ]  No | Click here to enter text. |
| Infectious disease (e.g., tuberculosis, hepatitis) | [ ]  Yes [ ]  No | Click here to enter text. |
| Allergies (seasonal or other) | [ ]  Yes [ ]  No | Click here to enter text. |
| Balance or coordination problems | [ ]  Yes [ ]  No | Click here to enter text. |
| Difficulty swallowing | [ ]  Yes [ ]  No | Click here to enter text. |
| Major surgery | [ ]  Yes [ ]  No | Click here to enter text. |
| **In the past year, have you experienced any of the following symptoms? If yes, please provide details.** | **Comments:** |
| Chest discomfort with exertion | [ ]  Yes [ ]  No | Click here to enter text. |
| Unexpected shortness of breath | [ ]  Yes [ ]  No | Click here to enter text. |
| Dizziness, fainting, or blackouts | [ ]  Yes [ ]  No | Click here to enter text. |
| Ankle swelling | [ ]  Yes [ ]  No | Click here to enter text. |
| Unpleasant awareness of forceful, rapid, or irregular heart rate | [ ]  Yes [ ]  No | Click here to enter text. |
| Burning or cramping sensations in lower legs when walking a short distance | [ ]  Yes [ ]  No | Click here to enter text. |
| Is there any other information about your health or medical history you want to share? | [ ]  Yes [ ]  No | Click here to enter text. |

# Current Health Habits

|  |
| --- |
| **Exercise** |
| **Do you exercise regularly?** | [ ]  Yes [ ]  No |
| **Describe your average weekly exercise regimen:** |
| Click here to enter text. |
| On average, how many days a week do you perform moderate to vigorous intensity physical activity or exercise where your heart is beating faster and your breathing is harder than normal (such as a brisk walk)? | **Days per week:** Click here. |
| On average, how many minutes do you engage in exercise at a moderate to vigorous level? | **Minutes per day:** Click here. |
| How many minutes per day or hours per week do you spend sitting? | **Minutes/day:** Click here.**Hours/week:** Click here. |
| Do you participate in muscle-strengthening activities? | [ ]  Yes [ ]  No |
| Do you perform balance-training activities? | [ ]  Yes [ ]  No |
| **Tobacco / nicotine use** |
| Do you currently use any tobacco or nicotine products? This includes cigarettes, cigars, chewing tobacco, vaping, etc. | [ ]  Yes [ ]  No |
| If yes, what type of products do you use? How much do you use on a daily basis?[ ]  Cigarettes: Click here. [ ]  Cigar: Click here. [ ]  Chew: Click here.[ ]  Snuff: Click here. [ ]  Vapor: Click here. [ ]  Other: Click here. |
| If you use tobacco or nicotine products, are you interested in quitting? | [ ]  Yes [ ]  No |
| **Alcohol use** |
| Do you drink alcohol? |  | [ ]  Yes [ ]  No |
| If yes, # of drinks per day: Beer: Click here. Wine: Click here. Liquor: Click here. |
| **Diet** |  |  |
| How would you rate your diet? | [ ]  Good [ ]  Fair [ ]  Poor |
| How many servings of fruits and vegetables do you eat per day? | Click here. |
| How many cups or ounces of water do you drink per day? | Click here. |

|  |
| --- |
| **Sleep** |
| Do you have difficulty falling asleep at night? |  | [ ]  Yes [ ]  No |
| Do you wake up at night? |  | [ ]  Yes [ ]  No |
| Do you snore or been told you snore? |  | [ ]  Yes [ ]  No |
| On average, how many hours do you sleep per night? | Click here. Hours |
| **Hearing** |  |  |
| Do you feel you have a hearing loss? |  | [ ]  Yes [ ]  No |
| **Functional activity review** |
| Can you walk four blocks (1/2 mile) at a brisk pace? | [ ]  Yes [ ]  No |
| How far can you walk before you get fatigued?  | Click here. |
| Can you climb one flight of stairs? | [ ]  Yes [ ]  No |
| How many flights of stairs can you climb before you get fatigued? | Click here. Flights |
| Can you carry five pounds of groceries up one flight of stairs without fatigue? | [ ]  Yes [ ]  No |
| Can you get on and off the floor by yourself? | [ ]  Yes [ ]  No |
| Can you stand up from a chair without using your arms? | [ ]  Yes [ ]  No |
| While standing, can you turn in a circle (360 degrees) to the right and/or left? | [ ]  Yes [ ]  No |
| Can you pick up a penny off the floor? | [ ]  Yes [ ]  No |
| Can you participate in strenuous sports, such as swimming, singles tennis, football, basketball, or skiing? | [ ]  Yes [ ]  No |
| Do you have difficulty with any other daily activity like dressing, bathing, toileting, getting in or out of a car? | [ ]  Yes [ ]  No |
| **Falls history** |
| Have you fallen in the past year? If so, how many times? Click here. | [ ]  Yes [ ]  No |
| Do you feel unsteady when standing or walking? | [ ]  Yes [ ]  No |
| Do you worry about falling? | [ ]  Yes [ ]  No |

**Template Last Updated:** 11/20/2020

**Contact:** practice@apta.org