



221 Hwy #53, Suite D  
Cook, MN 55723  
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Phone: (218)666-2697  
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<b>PATIENT INFORMATION</b> (Please Print)	
Patient's Name:	
Responsible Party:	
Relationship to Patient:	
Address:	
City:	
State:	Zip:
Home Phone:	Cell:
E-mail:	
Are you interested in receiving information via e-mail? Yes No	
Sex: M F	Age:
SSN:	DOB:
Marital Status: Single Married Widowed Separated Divorced	
<b>EMPLOYER INFORMATION</b>	
Employer:	
Address:	
City:	State: Zip:
Phone:	
Occupation:	
Working: Full Time Part Time Student Retired Unemployed	
<b>EMERGENCY INFORMATION</b>	
Name of Nearest Relative:	
Relation:	
Phone:	
<b>SOCIAL HISTORY</b>	
List any cultural/Religious beliefs or wishes that might affect your care:	
With whom do you live? Alone Spouse only Spouse and others Child (not spouse) Group Setting Other Relatives Personal Care Attendant Other:	
Who referred you to the Therapist?	

<b>LIVING ENVIRONMENT</b>
Private Home Private Apartment Rented Room Assisted Living Homeless with or without shelter Hospice Other
My home has: Stairs no railing Stairs with railing Ramps Elevator Uneven Terrain
<b>GENERAL HEALTH STATUS</b> (Please Rate Your Health)
Excellent Good Fair Poor
Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) Yes No
<b>SOCIAL/HEALTH HABITS</b>
Tobacco Use Yes No Packs per day: Former Smoker Year quit:
Alcohol Use Yes No Drinks per day: Day per week:
Do you Exercise beyond normal daily activities? Yes No Days Per Week:
<b>FAMILY MEDICAL HISTORY</b> (Please check all that apply)
Heart Disease Hypertension Stroke Diabetes Cancer Psychological Arthritis Osteoporosis Other:
<b>PERSONAL MEDICAL HISTORY</b> (Please check all that apply)
Arthritis Broken bones/fractures Osteoporosis Blood disorders Circulation/vascular problems Heart problems High blood pressure Stroke Lung problems Diabetes/high blood sugar Low Blood sugar Head injury Multiple Sclerosis Muscular dystrophy Parkinson disease Seizures Allergies Developmental/growth problems Thyroid problems Cancer Infectious disease (eg, tuberculosis, hepatitis) Kidney problems Repeated infections Ulcers/stomach problems Skin diseases Depression Other:



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In the past year, have you had any of the following symptoms? (check all that apply)	
Chest pain   Heart palpitations   Cough   Hoarseness Shortness of breath   Dizziness/blackouts Coordination problems   Weakness in arms or legs Loss of balance   Difficulty walking   Pain at night Difficulty sleeping   Joint pain or swelling Loss of appetite   Nausea/vomiting Difficulty swallowing   Bowel problems Weight loss/gain   Urinary problems Fever/chills/sweats   Headaches   Hearing problems Vision problems   Other:	
<b>SURGICAL HISTORY:</b> (Please list any surgeries. Include Month and year of surgery)	
<b>MEDICATIONS</b> (Please list any prescriptions)	
Non prescription Medications	
Advil/Aleve   Antacids   Ibuprofen/Naproxen Antihistamines   Aspirin   Decongestants Herbal supplements   Tylenol Other:	
<b>CURRENT CONDION(S)/CHIEF COMPLAINT(S)</b>	
Describe the reason you're seeking therapy	
When did the problem begin?	Date:
What Happened?	
Have you had the problem before?   Yes   No	
How long did it last?	
What are you doing to help the problem?	

What makes the problem worse?
What is the goal you hope to achieve with therapy?
<b>FUNCTIONAL STATUS</b> (Check all that apply)
Difficulty with:   Bed Mobility   transfers   Walking Self care (eg, toileting, bathing, eating, dressing) Home management (eg, household chores, shopping, driving) Work/school   Recreation/play activity Other:
Please indicate location of pain.