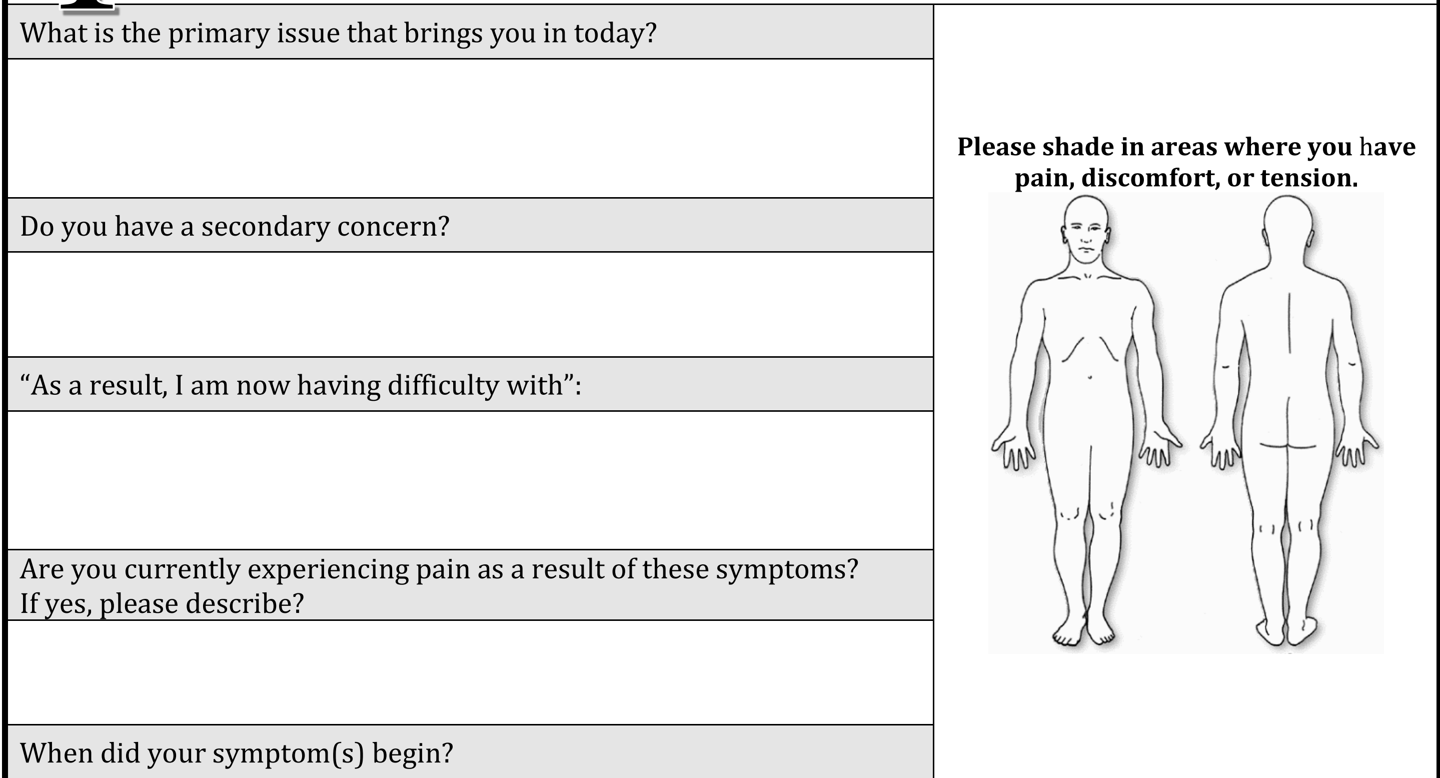
Artemis Physical Therapy Health and Wellness Information Sheet

1 *Your current condition*



What is the primary issue that brings you in today?	**Please shade in areas where you have pain, discomfort, or tension.**
Do you have a secondary concern?	
"As a result, I am now having difficulty with":	
Are you currently experiencing pain as a result of these symptoms? If yes, please describe?	
When did your symptom(s) begin?	

Rate your symptoms in the last 24-72 hours Using the "0 -10" scale where 0 is no pain and 10 is the worst possible pain.		
	At its worst	
	At its best	
	At present	
	While sleeping	

At what time of day are your symptoms the worst?	
At what time of day are your symptoms the best?	
What activities increase your pain?	
What activities decrease your pain?	

What other types of treatment have you had for this problem?					
☐ Massage	☐ Bodywork	☐ Physical Therapy	☐ Medications/Injections	☐ Chiropractic	☐ Surgery
Other Medical Treatment: (Please Describe)					

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List important activities you are unable or have difficulty performing as a result of your symptoms or pain and indicate your tolerance. If you are no longer able to perform an activity, your tolerance would be "0".	
Activity	Tolerance (minutes/hours)

I walk for		minutes before needing to rest		
I stand for		minutes before needing to sit		
I sit for		minutes before needing to change positions/get up		
Do you have trouble getting up from a chair?			Yes	No
Do you have trouble putting on your shoes and socks?			Yes	No
Do you have difficulty climbing stairs?			Yes	No

If sleep is a problem, answer these questions:

Do you have trouble falling asleep?	Yes	No	Do you find it difficult to change positions in bed?	Yes	No
Is your sleep restful?	Yes	No	How many times do you wake in the night?		
Do you find it difficult to lie down?	Yes	No	How long before you fall back to sleep?		

Do you have any other goals you would like to reach?

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2 *Brief Medical History*

Check the box if you have been diagnosed any of the following medical conditions?

☐Arthritis	☐Broken Bones	☐Circulation Problems	☐Diabetes	☐Epilepsy /Seizures
☐Heart Disease	☐Heart Murmur	☐High Blood Pressure	☐Kidney Disease	☐Liver Disease
☐Lung Disease	☐Malignancy	☐Metal Implants	☐Migraine Headaches	☐Neurological Problems
☐Osteoporosis	☐Pacemaker	☐Pregnancy	☐Rheumatic Fever	☐Stroke

☐Other: (please explain)

Have you RECENTLY noted any of the following? (check all that apply)

☐Changes In Bowel Or Bladder Function	☐Fever/Chills/Sweats	☐Weakness/Fatigue
☐Weight Loss/Gain	☐Shortness Of Breath	☐Changes In Appetite
☐Nausea/Vomiting	☐Pain At Night	☐Difficulty Swallowing
☐Dizziness/Lightheadedness	☐Headaches	

☐Other: (please explain)

List any surgeries, accidents and other traumas.

List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

Medication	For treatment of	Dose / Amount per day	Effectiveness

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Is there a chance you may be pregnant at this time?	YES NO

List all allergies:				
Are you latex sensitive?	YES NO	Are you sensitive to adhesive bandages?	YES NO	

3 *Lifestyle*

Do you engage in regular exercise?					YES NO
What type and how often?					
Are you able to exercise now?					YES NO
Do you have discomfort, shortness of breath, or pain with exercise?					YES NO
Please Describe:					
In general, your lifestyle is:	1	2	3	4	5
	Active		Average		Inactive
Do you smoke?	YES NO		If "Yes'-How Much?		

Is there anything else you would like to share regarding your condition, goals, medical history or lifestyle?

I hereby agree that the above information is true to the best of my knowledge and will inform Artemis Physical Therapy if my status changes.

X ______________________________ X ____________
Date