Dee PT
integrated rehabilitation • therapy • fitness

Name:______________________
DOB:__________Age:________
Todays Date:________________
Chart #:_________

Client History Information

****Please fill out to the best of your ability and focus on what is pertinent to your visit with us today****

General Health Status

Please rate your health: __ Excellent __ Good __ Fair __ Poor
Exercise: __ None __Moderate __Daily __Heavy __Athlete
Health Habits: __Alcohol __Water __Coffee/Caffeine __Stress
Any Major Life Changes in the Last Year? (eg, new baby, job change, death in the family) __ Yes __No
If yes, please describe: ____

Family History

Please list if your father, mother, sibling, aunt/uncle or grandparent has had any of the following conditions and the age of onset if known.

Arthritis: _____________________________
Diabetes: _____________________________`
Hypertension: _________________________
Psychological: _________________________
Other: ________________________________
Cancer: _____________________________
Heart Disease: ________________________
Osteoporosis: _________________________
Stroke: ______________________________
Other: _______________________________

Medical/Surgical History Please check if you have ever had:

__Arthritis
__Asthma
__Blood Disorders
__Cancer
__Circulation/Vascular Problems
__Depression
__Developmental/Growth Issues
__Diabetes/High Blood Sugar
__Head Injury
__Heart Problems
__High Blood Pressure
__High Cholesterol
__Infectious Disease (TB, Hepatitis)
__Kidney Problems
__Low Blood Sugar/Hypoglycemia
__Lung Problems
__Migraine Headaches
__Multiple Sclerosis
__Muscular Dystrophy
__Osteoporosis
__Parkinsons
__Repeated Infections
__Seizures/Epilepsy
__Skin Disease
__Stroke
__Thyroid Problems
__Ulcers/Stomach Problems

Other: ____

Broken Bones/Fractures (include dates)
____________________ __/__/__
____________________ __/__/__

Surgeries (include dates)
__________________________ __/__/__
__________________________ __/__/_

Allergies: ____
Supplements/Herbs: ____
____

Medications: (Dosage and Frequency)____
____

Insurance requires the following information for ALL PATIENTS

Height* _____________ Weight* _______________
**Have you fallen in the past year? Yes / No
**If you have fallen in the past year, did you sustain an injury from that fall? Yes / No
***Do you currently use any type of tobacco product? Yes / No

Turn Over

Employment/Recreation

Are you: __A Student __Employed __Unemployed __ A Homemaker __Retired

Hobbies/Sports: ____

Current Employment: Occupation ____________________________ __Part-time __Full-time

Work Activity: __ None __ Sitting __Standing __Light Labor __Heavy Labor

Out of Work Due to Injury?: __No __Yes, please describe: __________________________________

Work Restrictions?: __No __Yes, please describe: ____

Current Condition/Chief Complaint

Reason for Visit: ____

Is this condition: ___A New Problem __A Chronic Problem __Unknown

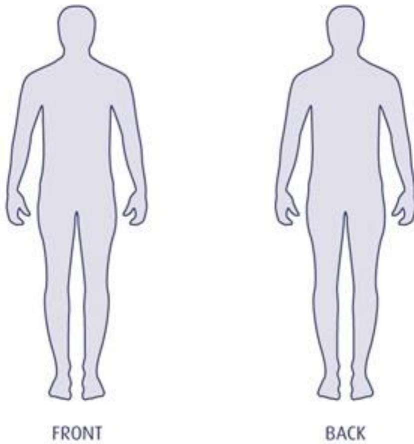
When did symptoms appear?: ____________________ Is it getting worse?: __Yes __No __Unknown

What makes the problem(s) better?: ____

What makes the problem(s) worse?: ____

What are your goals for physical therapy?: ____

Please circle the location of your pain or where you may be having difficulty functioning, and circle your level of pain on the right.



10 Worst pain

8 Very Severe

6 Severe

4 Moderate

2 Mild

0 No Pain

Are you seeing anyone else for the problem(s)?: *Please check all that apply*

__Acupuncturist __Cardiologist __Chiropractor __Dentist

__Family Practitioner __Internist __Massage Therapist __Neurologist

__OBGYN __OT __Orthopedist __Osteopath

__Pediatrician __Podiatrist __Primary Care Dr. __Rheumatologist

__Other: ____

Is your problem(s) affecting your daily activities?: *Please check all that apply*

__Bed Mobility __Walking __Driving __Recreation

__Shopping __Household Care __Dependent Care __Self Care (bathing, dressing etc)

Patient/Guardian Signature: _________________________________ Date: ____________________

23 San Remo Drive South Burlington, VT 05403 – 802.865.0010
166 Athletic Drive Shelburne, VT 05482 – 802.985.4440
52 Farmall Drive Hinesburg, VT 05461 – 802.482.2200

Turn Over