Date: _____ Name: _____

DOB: _____ Acct: _____

Insurance:

Patient Health History and Information

Age: _____ **Height:** _____ **Weight:**_____ **Sex:** M F **Pronoun:** He/Him She/Her They/Them

Dominant hand: R L **Could you be or are you pregnant:** Yes No

Reason for Therapy:_____

Date of injury/onset of symptoms: ___/___/___ **Surgery for this condition**: Yes/ No Date ___/___/___ Type _____

Please describe how your injury/problem occurred:_____

Please list any treatment you have received for this condition(ie. PT, chiro)_____

For this condition have you had any of the following? EMG___/___/___ X-ray ___/___/___ MRI / CT scan ___/___/___

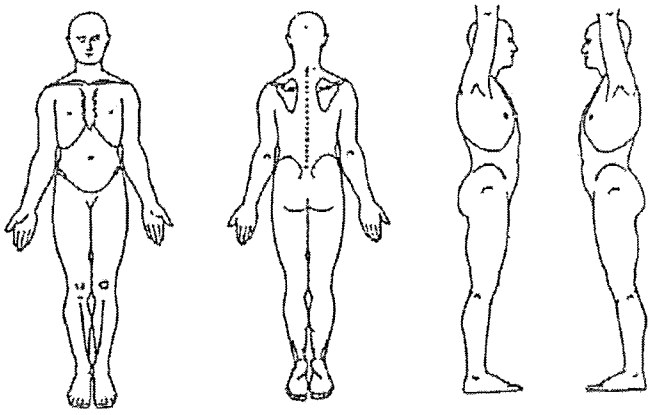
Injection: type: _____ ___/___/___ Other:_____ ___/___/___

Have you had this problem before? Y/N When?_____ What kind of treatment?_____

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain //= Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing		Increasing		Staying the same	
Weakness	Giving way	Throbbing	Other:_____		

What makes your symptoms worse? _____

What makes your symptoms better? _____

Limitations due to your current problem:_____

____Laying down	____Bending	____Turning Head	____Sleep/Awake from Pain
____Sit to stand	____Work	____Sitting	____Self Care/Hygiene
____Up/Down Stairs	____Driving	____Walking	____Home activities
____Squatting/Lifting	____Swallowing	____Standing	____Repetitive activities
____Looking overhead	____Talk/Chew/Yawn/All	____Reaching	____Sport/Recreation
____Taking a breath	____ Cough/sneeze pain	____Child care	

What are your goals for therapy? (Two things you want to be able to do again or do better)

1._____ **2.** _____

How did you hear about Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

GENERAL HEALTH HISTORY:

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other:_____	Yes	No
Headaches	Yes	No			

Have you had any falls or near falls in the past year? Yes/No. If yes, how many _____

Rate your overall health: Excellent Good Average Poor **Living Situation:** Alone Spouse Family Others

Do you exercise? Yes / No _____x/week Type:_____ **Do you smoke?** Yes/ No **Do you drink caffeinated beverages?** Yes/No ___/wee

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Anxiety	Self	Family	No	Thyroid problems	Self	Family	No
Cancer	Self	Family	No	Epilepsy/dizziness	Self	Family	No
High Cholesterol	Self	Family	No	Tuberculosis	Self	Family	No
High blood pressure	Self	Family	No	Anemia/blood disorder	Self	Family	No
Heart trouble/angina	Self	Family	No	Multiple Sclerosis	Self	Family	No
Diabetes	Self	Family	No	Circular/vascular problems	Self	Family	No
Stroke	Self	Family	No	Chemical dependency	Self	Family	No
Osteoporosis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Osteoarthritis	Self	Family	No	AIDS/HIV	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Hepatitis	Self	Family	No
Depression	Self	Family	No	Bladder/bowel problems	Self	Family	No
Headaches	Self	Family	No				
COVID-19	Self	Family	No	Other:_____			

SURGICAL HISTORY (please list any surgeries): _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: No _____ Yes _____

WORK HISTORY:

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC and/or Adjuster (if you have one):_____

Patient Signature: _____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

Creekside
Physical Therapy

NAME:_____ **ACCOUNT #:**_____ **DOB:**_____ **SCORE:** _____ **DATE:** _____

TMJ Activities Questionnaire

Please read: This questionnaire has been designed to give the therapist information as to how your jaw pain has affected your ability to manage in everyday life. Please answer every section, marking only ONE line which best describes your status TODAY. We realize you may consider two of the statements in any one section relate to you, but please mark ONLY ONE line which most closely describes your problem.

1. I can chew bagels, steak, raw carrots, French bread, apples and licorice...

___ Without pain or fatigue.
___ Some of the time without pain and/or fatigue.
___ But I experience fatigue.
___ But I experience pain and/or fatigue.
___ But I stop after several bites because of pain and/or fatigue.
___ I am unable to chew these foods because of pain and/or fatigue.

2. I can chew sandwiches, chicken, pizza, salads, crackers, hamburgers, cornflakes...

___ Without pain or fatigue.
___ Some of the time without pain and/or fatigue.
___ But I experience fatigue.
___ But I experience pain and/or fatigue.
___ But I stop after several bites because of pain and/or fatigue.
___ I am unable to chew these foods because of pain and/or fatigue.

3. I can chew pasta, casseroles, baked potatoes, bananas, rice and fish...

___ Without pain or fatigue.
___ Some of the time without pain and/or fatigue.
___ But I experience fatigue.
___ But I experience pain and/or fatigue.
___ But I stop after several bites because of pain and/or fatigue.
___ I am unable to chew these foods because of pain and/or fatigue.

4. I can chew eggs, cottage cheese and oatmeal...

___ Without pain or fatigue.
___ Some of the time without pain and/or fatigue.
___ But I experience fatigue.
___ But I experience pain and/or fatigue.
___ But I stop after several bites because of pain and/or fatigue.
___ I am unable to chew these foods because of pain and/or fatigue.

5. Biting into foods:

___ I can bite into hard foods (bagel, steak, apples, carrots) without any extra pain.
___ I can bite into hard foods, but it gives me extra pain.
___ I can bite into regular foods (sandwiches, chicken, pasta, salad) without extra pain.
___ I can bite into only semi-soft foods (pasta, cookies, sandwich bread) without extra pain.
___ I am unable to bite because of factors other than pain (weakness, open bite, post-op).
___ Pain prevents me from biting into any foods.

OVER

NAME:_____ ACCOUNT #:_____ DATE:_____

6. Smiling/Laughing:

___ I can smile as long as I want without extra pain.
___ I can smile as long as I want, but it gives me extra pain.
___ Pain prevents me from smiling/laughing more than 1 hour.
___ Pain prevents me from smiling/laughing more than 30 minutes.
___ Pain prevents me from smiling/laughing more than 1 minute.
___ Pain prevents me from smiling/laughing at all.

7. Talking:

___ I can talk as long as I want without any extra pain.
___ I can talk as long as I want, but it gives me extra pain.
___ Pain prevents me from talking more than 1 hour.
___ Pain prevents me from talking more than 30 minutes.
___ Pain prevents me from talking more than 1 minute.
___ Pain prevents me from talking at all.

8. Yawning:

___ I can yawn at full opening without any extra pain.
___ I can yawn at full opening, but it gives me extra pain.
___ I can yawn at 3 fingers opening, but it gives me extra pain.
___ I can yawn at 2 fingers opening, but it gives me extra pain.
___ I can yawn at 1 finger opening, but it gives me extra pain.
___ Pain prevents me from yawning at all.

9. Brushing Teeth:

___ I can brush my teeth without extra pain.
___ I can brush my teeth some of the time without pain.
___ I can brush my teeth, but I fatigue.
___ I can brush my teeth, but it gives me extra pain.
___ I can brush my front teeth without extra pain.
___ Pain prevents me from brushing my teeth at all.

10. Sleeping:

___ Pain does not prevent me from sleeping well.
___ Pain interrupts my sleep 1x during the night.
___ Pain interrupts my sleep 2x during the night.
___ Pain interrupts my sleep 3x during the night.
___ Pain interrupts my sleep 4 or more times during the night.
___ Pain prevents me from sleeping at all.

11. Have you or others noticed yourself regularly (more than once per week)...Check all that apply.

___ Chewing on one side only?
___ Clenching/Grinding your teeth when awake? **(circle)**
___ Chewing gum?
___ Holding or pressing the tongue against your teeth?
___ Touching or holding your teeth together?
___ Holding your jaw forward, or in a rigid position?
___ Leaning on jaw?
___ Biting your lips, tongue, cheeks, nails, objects (pencils, hard candy)? **(circle all that apply)**
___ Clenching/Grinding your teeth at night? **(circle)**
___ Waking up with sore jaws?
___ Sleeping on stomach?
___ Play musical instrument (using mouth)? _____ (instrument)
___ Do you sing regularly?
___ Do you have/wear an appliance (mouth guard) at night or have you had an appliance in the past?
___ Have you worn braces? _____ (date)
___ None Apply

Creekside
Physical Therapy

Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:		Patient updated:	Date:
Therapist reviewed:	Date:		Therapist reviewed:	Date: