|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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

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| --- | --- | --- |
| **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

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| --- | --- | --- |
| **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. |

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| **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 |

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