

DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Outpatient Form 1, Page 1

Today's Date: _____
Patient ID#: _____

1 Name:

a Last: _____
b First: _____ c MI: _____ d Jr/Sr: _____

2 Street Address:

City: _____ State: _____ Zip: _____

3 Date of Birth:

Month: [] [] Day: [] [] Year: [] [] [] []

4 Sex: a ☐ Male b ☐ Female

5 Are you: a ☐ Right-handed b ☐ Left-handed

6 Type of Insurance: a ☐ Insurer _____

b ☐ Workers' Comp c ☐ Medicare d ☐ Self-pay e ☐ Other _____

7 Race:

- a ☐ American Indian or Alaska Native
- b ☐ Asian
- c ☐ Black or African American
- d ☐ Hispanic or Latino
- e ☐ Native Hawaiian or Other Pacific Islander
- f ☐ White

8 Ethnicity:

- a ☐ Hispanic or Latino
- b ☐ Not Hispanic or Latino

9 Language:

- a ☐ English understood
- b ☐ Interpreter needed
- c ☐ Language you speak most often: _____

10 Education:

- a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
- b ☐ Some college / technical school
- c ☐ College graduate
- d ☐ Graduate school / advanced degree

SOCIAL HISTORY

11 Cultural/Religious: Any customs or religious beliefs or wishes that might affect care?

12 With whom do you live:

- a ☐ Alone
- b ☐ Spouse only
- c ☐ Spouse and other(s)
- d ☐ Child (not spouse)
- e ☐ Other relative(s) (not spouse or children)
- f ☐ Group setting
- g ☐ Personal care attendant
- h ☐ Other: _____

13 Have you completed an advance directive? a ☐ Yes b ☐ No

14 Who referred you to the physical therapist:

15 Employment/Work (Job/School/Play):

- a ☐ Working full-time outside of home
- b ☐ Working part-time outside of home
- c ☐ Working full-time from home
- d ☐ Working part-time from home
- e ☐ Homemaker
- f ☐ Student
- g ☐ Retired
- h ☐ Unemployed
- i Occupation: _____

LIVING ENVIRONMENT

16 Does your home have:

- a ☐ Stairs, no railing
- b ☐ Stairs, railing
- c ☐ Ramps
- d ☐ Elevator
- e ☐ Uneven terrain
- f ☐ Assistive devices (eg, bathroom): _____
- g ☐ Any obstacles: _____

17 Do you use:

- a ☐ Cane
- b ☐ Walker or rollator
- c ☐ Manual wheelchair
- d ☐ Motorized wheelchair
- e ☐ Glasses, hearing aids
- f ☐ Other: _____

18 Where do you live:

- a ☐ Private home
- b ☐ Private apartment
- c ☐ Rented room
- d ☐ Board and care / assisted living / group home
- e ☐ Homeless (with or without shelter)
- f ☐ Long-term care facility (nursing home)
- g ☐ Hospice
- h ☐ Other: _____

19 GENERAL HEALTH STATUS

a Please rate your health:

- (1) ☐ Excellent (2) ☐ Good (3) ☐ Fair (4) ☐ Poor

b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1) ☐ Yes (2) ☐ No

20 SOCIAL/HEALTH HABITS

a Smoking:

- (1) Currently smoke tobacco? (a) ☐ Yes 1. ☐ Cigarettes: # of packs per day ____
2. ☐ Cigars/Pipes: # per day ____
- (b) ☐ No

- (2) Smoked in past? (a) ☐ Yes Year quit: [] [] [] [] (b) ☐ No

b Alcohol:

- (1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? ____
- (2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? ____

c Exercise:

Do you exercise beyond normal daily activities and chores?

- (a) ☐ Yes Describe the exercise: _____
1. On average, how many days per week do you exercise or do physical activity? ____
2. For how many minutes, on an average day? ____
- (b) ☐ No

21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)

- a Heart disease: _____
- b Hypertension: _____
- c Stroke: _____
- d Diabetes: _____
- e Cancer: _____
- f Psychological: _____
- g Arthritis: _____
- h Osteoporosis: _____
- i Other: _____

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Cikulin-Kulinski



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