Petaluma Orthopaedic and Sports Therapy

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Director

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: ____________