Telan Nelson, PT

CA Licensed Physical Therapist #38927

Phone: (530) 492-0116

www.telanpt.com

CLIENT CONTACT INFORMATION

Name: ____ Date: ____________________________

Address: _____________________________________ City, State, Zip: _____________________________

Home Phone: _________________ Cell/Work Phone: ____________________ Birthdate: ______________

E-Mail Address: ____

Emergency Contact: ___________________________________ Phone: ____________________________

Primary Care Physician: ____

Referring Physician: ____

Do you authorize Telan Nelson, PT to communicate with your listed physician(s) regarding findings of Initial Evaluation and treatment? Yes ______ No _______ Initials ________

HEALTH QUESTIONNAIRE

Describe your main concern(s): ____

____

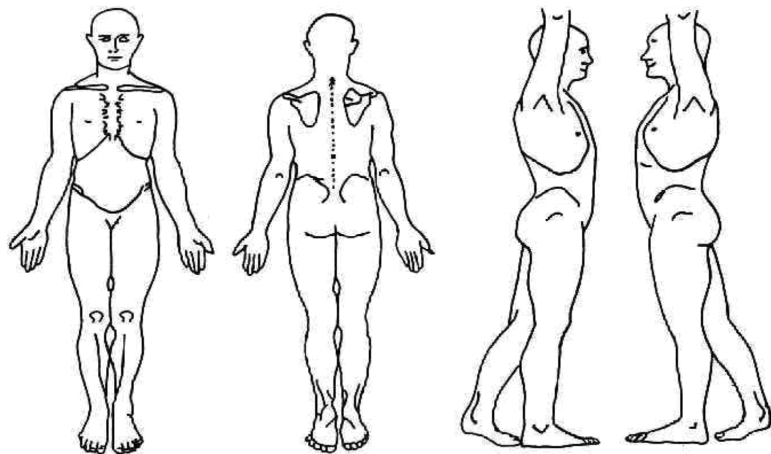
____

Please mark your symptoms on the body chart:

XX = Pain

OO = Numbness

WW = Weakness



Please circle the level of your current pain:

No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Is problem O **improving** O **same** O **worsening**

Date problem began? ____________________

How did this problem begin? ____

____

What makes symptoms worse? ____

What makes symptoms better? ____

Does pain wake you at night? ___________ **How often?** _______________

What percent of your day are symptoms present? ______%

Have you undergone any special tests for this problem? (X-rays, MRI's, ETC) If yes, do you know the results? ____

Do you now have or have you had any of theses symptoms in the past year? ***(check all that apply):***

___ Dizziness	___ High Blood Pressure	___ Unexplained weight change
___ Headaches	___ Low Blood Pressure	___ Any history of cancer or a tumor
___ Ringing in ears/ Tinnitus	___ Heart Problems	___ Bowel or Bladder issues
___ Recent change in vision	___ Respiratory Problems	___ Rheumatoid Arthritis
___ Vertigo	___ Bruising/bleeding disorder	___ Osteoporosis/Osteopenia
___ Fainting	___Skin changes, rashes	___ Are you Pregnant?
___ Diabetes	___ Intolerance to hot/cold	

Any other medical problems? ____

____

Any prior surgeries? If yes, please list dates: ____

____

Please list your medications: ____

____

Weight: _______ **Height**: ________ **Occupation**: ____

Have you fallen in the past 12 months? O Yes O No

Do you exercise? O Yes O No **How often?** ______________ **Type**: ____________________________

Do you smoke? O Yes O No **How much?** _______________