kinetacare
2418 E. Bridge St. Brighton, CO 80601
Phone: (303) 655-8699 Fax: (303) 655-8698

***Patient*:**
Name: ______________________________ Birthdate: __________________ Today's Date ___________
Age:________________________________ Occupation: ______________________________________
Height, Weight:______________________ Date of Injury: _____________________________________
Did a physician refer you? If yes whom? ________________Next scheduled appointment_____________
If no, do you have a doctor you would like us to communicate with regarding your care? ___________
Physician's contact information: ____

Medical History:
Please check if any apply to your or someone in your family: **(Y=you, N=no, F=family member)**

Condition	Y	N	F	Condition	Y	N	F	Condition	Y	N	F
High Blood Pressure				Cancer				Kidney Problems			
Cardiac Conditions				Dizzy Spells				Gall bladder problems			
Cardiac Pacemaker				Vision Problems				Depression			
Circulation Problems				Speech Problems				Anxiety			
Osteoporosis				Strokes				Fractures			
Arthritis				Seizures				Metal Implants			
Diabetes				Allergies				Currently Pregnant			

Other Conditions: ____
____

Have you had an injury related to a fall in the past year? (Circle yes or no) Yes No
Have you had two or more falls in the last year? Yes No
Have you **ever** had surgery? Yes/No If yes, please describe, and include dates:
____
____
Current Medications with dosage: (attach sheet if additional medications are being taken)

Medication	Dosage	Reason for use

c – Please circle if you have had any of the following symptoms/conditions in the last year.

1 – Chest pain
2 – Heart palpitations
3 – Cough
4 – Shortness of breath
5 – Dizziness
6 – Coordination problems
7 – Weakness in arms or legs
8 – Loss of balance
9 – Difficulty walking
10 – Joint pain or swelling
11 – Night pain
12 – Difficulty sleeping
13 – Loss of appetite
14 – Nausea/Vomiting
15 – Bowel or bladder problems
16 – Fever/chills/sweat
17 – Headaches
18 – Hearing problems
19 – Vision problems
20-- Pregnant
21—Depression
22—Highly stressed
23 – Other ______________
____

Social History:
a – With whom do you live?____
b – Sleep Patterns: Hours: _____ # times awake/night _____
Reason for wakefulness ____
c – Do you use an assistive device for mobility?_______, If so, what?__________________________

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d – Do you smoke?______________________ Do you drink alcohol?___________________________

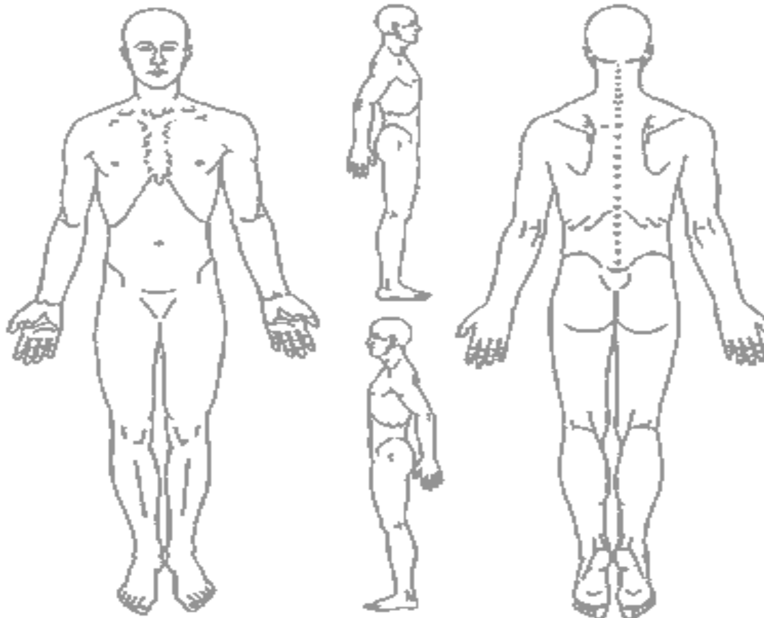
e – How many days a week do you exercise?____

f – How would you rate your health?   Excellent   Good   Fair   Poor

g – When was the date of your last complete physical? (Month/year/physician) __________________

Please rate your pain on a scale from 0-10, 0 being none and 10 being maximum pain you could experience.
Today:______ Best: ______ Worst:_______ Worse am / pm with movement / being stationary
Activities that cause you pain: ____
____

Mark areas on the drawing below where you feel the described sensations using the appropriate symbols. Include all affected areas.
Dull Ache (*)
Stabbing (/)
Numbness (X)
Pin/Needles (+)
Burning (O)



Current condition(s)/chief complaint(s):
a - When was the onset of your problem/injury? ____
b - Was this condition related to an auto or work accident? _____________________________
c - Describe the problem(s) for which you seek therapy? ________________________________
____
d – Are the problem(s) getting better, staying the same or getting worse? ________________________
____
e – How did the problem(s) begin?____
____
f - Have you had this problem before? ____
____
g- What usual daily activities are being affected? _______________________________________
____
h- What are your goals for therapy? ____
____
i - Have you or are you seeing anyone else for the problem(s ______________________________