

Function Ability Physical Therapy
Specializing in Alternative Techniques and Women's Health
Debora Hickman DPT, CLT-LANA

Patient's Self-Reported Medical Information

Welcome to Function Ability Physical Therapy. It is our hope that we can assist you with your current and future health concerns. Our focus is: health improvement, maintenance, prevention, and education. Any current health problems may be indicators of underlying imbalances. Part of our responsibility will be to explore your overall health status, assess the possible root cause of your complaints and to advise you on measures to ensure optimal well being.

During the course of your examination and treatments, please feel free to comment, ask questions and provide us with feedback. We feel that the more you know about yourself, the more active a role you can play in restoring and maintaining your own health.

Together, we can form a team on the side of a healthy future.

Name: _____

Phone: Home _____ Work _____ Cell _____

Address: _____

Age: _____ Birth date: Month _____ Day _____ Year _____

Sex: Male _____ Female _____

Referred by: _____

Occupation: _____ Employer: _____

Significant Status: Single __ Married __ Separated __ Divorced __ Widowed __ Other __

Number of Children: _____ Ages: _____

Have you previously received Physical Therapy treatment? _____

Explain: _____

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Patient's Name: _____

Confidential Health and Lifestyle Questionnaire

Please complete this questionnaire with care. Your answers will help us to determine the most effective health care for you. Please print throughout. Thank you.

What are your health concerns, in order of importance to you?

1. _____
2. _____
3. _____
4. _____
5. _____

If there is a specific condition, how long has it been occurring? _____

Have you had similar problems before? Yes ___ No ___

Do you have any relatives with similar problems? Yes ___ No ___

List Diagnoses, types of treatments, medications, etc _____

List any medications and doses you are currently taking: _____

Have you had any X-rays, MRI or full body scan taken in the last three years? Yes/No

What did the images reveal? _____

What do you feel the causes of your health problems are? _____

When did you last feel well? _____

Please indicate the occurrences of the following and give details and dates:

Surgeries: _____ Hospitalizations: _____

Seizures: _____ Major Illnesses: _____

Loss of Consciousness: _____

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Patient's Name: _____

Accidents/Injuries:

Height: _____ Weight: _____

Are you satisfied with your present weight? Yes ___ No ___

Have you ever had a weight problem? Yes ___ No ___

Are you constipated? Yes ___ No ___ Number of bowel movements per day: _____

Do you exercise regularly? Yes ___ No ___ How often? _____

What type of program? _____

If not, what type of exercise would you like to do? _____

What are the things you find stressful? _____

What things do you do for relaxation? _____

List your hobbies: _____

How many hours of sleep do you get per night? _____

Do you drink coffee, black tea or coke? Yes ___ No ___ Number per day? _____

Do you smoke? Yes ___ No ___ How long: _____ Number per day: _____

Do you drink alcohol? Yes ___ No ___ Daily amount: _____ Weekly amount: _____

If you are a **female**, when was your last menstrual cycle? _____

Do you have any leakage problems or urgency to get to a bathroom? Yes ___ No ___

Have you had a bone scan? Yes ___ No ___ What is your T-score? _____

How many pregnancies have you had? _____ How many deliveries? _____

List complications if any: _____

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Patient's Name: _____

If there is a history of any of the following in your family, please circle and state the relationship of the family member.

Alcoholism	Cancer	Heart Disease	Schizophrenia
Allergies	Cataracts	Hyperactivity	Stomach Ulcers
Arteriosclerosis	Celiac	Kidney Disease	Stroke
Arthritis	Colitis	Learning Disability	Tuberculosis
Asthma	Depression	Mental Disease	Yeast Infections
Bed Wetting	Diabetes	Muscular Dystrophy	Venereal disease
Candida Albicans	Epilepsy	Multiple Sclerosis	

We are pleased you have chosen Function Ability Physical Therapy. Please bring your diagnosis from your doctor with you to your first visit. If you plan to submit your bill to your PPO for the visit you must bring an MD prescription for physical therapy evaluation and treatment stating your diagnosis, frequency and duration.

Dr. Debora Hickman PT, CLT-LANA