

Stephen C. Helton, PT: Physical Therapist
Initial Examination Orthopedic

Name: _____ **Referral:** _____ **Date:** _____

Employment/Work (Job/School/Play):

Work Status: Unemployed Working Full-time Working light duty Student
 Homemaker Working Part-time Disabled Retired

Occupation: _____

Your Work Involves: Prolonged Standing Working with a bent neck Lifting Light Objects
(Check all that apply) Prolonged Sitting Frequent typing Lifting Heavy Objects
 Prolonged Walking Repetitive overhead work Carrying Light Objects
 Prolonged Driving Excessive reaching Carrying Heavy Objects
 Prolonged forward bending Frequent hand grasping Repetitive pushing/pulling
 Exposure to vibrating tools Climbing ladders Repetitive arm motions
 Exposure to temperatures Excessive stair climbing Repetitive foot motions
 Other: _____

Medications & Allergies – Please check or list all current medications and allergies:

Non-Prescription: No Medications Decongestants Motrin
 Advil/Alleve Exedrin Vitamins/minerals
 Antihistamines Herbal Supplements Tylenol
 Aspirin Ibuprophen/Naproxen _____

Prescription: No Medications _____

Allergies: No Known Allergies To Date _____

Surgical History – Please list any surgeries you have had, and if known, include dates:

No Surgeries to Date

1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

Past Symptom History Checklist – Within the past year, have you had any of the following (check all that apply):

<input type="checkbox"/> No Symptoms in Past Year	<input type="checkbox"/> Difficulty Walking	<input type="checkbox"/> Joint Pain or Swelling	<input type="checkbox"/> Tremors
<input type="checkbox"/> Bowel problems	<input type="checkbox"/> Dizziness/Blackouts	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Urinary Problems
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Excessive Sweating	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Cough (persistent)	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Weakness in arms
<input type="checkbox"/> Decreased coordination	<input type="checkbox"/> Headaches	<input type="checkbox"/> Numbness in arms/legs	<input type="checkbox"/> Weight Gain (unexplained)
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Pain at Night	<input type="checkbox"/> Weight Loss (unexplained)
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/>