DR. REAMS
CONCIERGE PT LLC

Date: _____
Name: _____ Height_____Weight _____ Age _____
DOB: _____ Occupation: _____
Living environment: _____ Do you live alone? Yes No
If no, who do you live with:_____

Does your home have:
___Stairs, no railing ___Stairs, w/railing ___Ramps
___Elevator
___Uneven Terrain ___Other: _____

General Health
Do you use:
___Cane
___Walker or rollator ___Manual Wheelchair ___Motorized wheelchair
___Other_____

Please rate your health:
___Excellent ___Good ___Fair ___Poor

Health Habits
Do you exercise regularly? _____ Yes _____No
If yes, how often and what type of activities?
_____
_____
How much water do you drink daily? _____oz

Do you smoke? ____Yes ____ No
If yes, how many packs per day? ____

Medications:
Do you take any prescription medications? ___ Yes ___ No

If yes, please list:

_____
_____
_____
_____

Past Medical History:
Please check if you have ever had:

___ High blood pressure
___ Arthritis
___ Blood disorders
___ Broken bones
___ Cancer
___ Vascular problem
___Depression
___ Infectious disease (such as tuberculosis, hepatitis)
___ Kidney problems
___ Multiple Sclerosis
___ Latex Allergy
___ Low blood sugar
___ Lung problems
___ Multiple sclerosis
___ Osteoporosis
___ Developmental problems
___ Diabetes
___ Stroke
___ Thyroid problems
___ Parkinson's diseases
___ Seizures/epilepsy
___ Heart problems
___ Skin Disease
___ Fibromyalgia
___ Urinary Problems

Other _____

Surgical History (please list surgery and month/year)

_____ __/___ _____ __/__
_____ __/___ _____ __/__

For Men Only

Have you been diagnosed with prostate disease? Yes/No

For Women Only

Are you pregnant or think you may be pregnant? Yes/No
Have you been diagnosed with other OBGYN problems? Yes/No
If yes what _____
Have you had surgery related to women's health? Yes/No

If yes what and when _____

History of Current Problem(s)
When did the problem(s) begin? ___/___/___ What occurred?

_____

_____ _____

Have you ever had the problem(s) before? __ Yes ___ No
What did you do for the problem(s)?

_____

_____

Did the problem(s) get better? ___ Yes ___ No
How long did the problem last? _____
What makes the problem better / worse

_____

_____

What activities are you not able to do now that you could do before the problem(s)? (Please be as specific as you can; for instance "Unable to reach over my head")

_____

_____

Rate the level of your pain on the following scale.
At present: 0 1 2 3 4 5 6 7 8 9 10
At best: 0 1 2 3 4 5 6 7 8 9 10
At worst: 0 1 2 3 4 5 6 7 8 9 10

Please draw pain on body chart (see below)
Pain description please circle where pain is and note with symbol type of pain:
+ = numbness
0 = pins/needles
****=sharp**
X=burning
S=aching
#=dull