

# DOCUMENTATION TEMPLATE FOR PHYSICAL THERAPIST PATIENT/CLIENT MANAGEMENT

Outpatient Form 1, Page 1

Today's Date: \_\_\_\_\_  
Patient ID#: \_\_\_\_\_

**1 Name:**

a Last: \_\_\_\_\_  
b First: \_\_\_\_\_ c MI: \_\_\_\_\_ d Jr/Sr: \_\_\_\_\_

**2 Street Address:** \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**3 Date of Birth:**      Month      Day      Year  
         

**4 Sex:**    a  Male    b  Female

**5 Are you:**    a  Right-handed    b  Left-handed

**6 Type of Insurance:**    a  Insurer: \_\_\_\_\_  
 b  Workers' Comp    c  Medicare    d  Self-pay    e  Other

**7 Race:**

- a  American Indian or Alaska Native
- b  Asian
- c  Black or African American
- d  Hispanic or Latino
- e  Native Hawaiian or Other Pacific Islander
- f  White

**8 Ethnicity:**

- a  Hispanic or Latino
- b  Not Hispanic or Latino

**9 Language:**

- a  English understood
- b  Interpreter needed
- c  Language you speak most often: \_\_\_\_\_

**10 Education:**

- a Highest grade completed (Circle one): 1 2 3 4 5 6 7 8 9 10 11 12
- b  Some college / technical school
- c  College graduate
- d  Graduate school / advanced degree

**SOCIAL HISTORY**

**11 Cultural/Religious:** Any customs or religious beliefs or wishes that might affect care? \_\_\_\_\_

**12 With whom do you live:**

- a  Alone
- b  Spouse only
- c  Spouse and other(s)
- d  Child (not spouse)
- e  Other relative(s) (not spouse or children)
- f  Group setting
- g  Personal care attendant
- h  Other: \_\_\_\_\_

**13 Have you completed an advance directive?**    a  Yes    b  No

**14 Who referred you to the physical therapist:** \_\_\_\_\_

**15 Employment/Work (Job/School/Play)**

- a  Working full-time outside of home
- b  Working part-time outside of home
- c  Working full-time from home
- d  Working part-time from home
- e  Homemaker
- f  Student
- g  Retired
- h  Unemployed
- i Occupation: \_\_\_\_\_

**LIVING ENVIRONMENT**

**16 Does your home have:**

- a  Stairs, no railing
- b  Stairs, railing
- c  Ramps
- d  Elevator
- e  Uneven terrain
- f  Assistive devices (eg, bathroom): \_\_\_\_\_
- g  Any obstacles: \_\_\_\_\_

**17 Do you use:**

- a  Cane
- b  Walker or rollator
- c  Manual wheelchair
- d  Motorized wheelchair
- e  Glasses, hearing aids
- f  Other: \_\_\_\_\_

**18 Where do you live:**

- a  Private home
- b  Private apartment
- c  Rented room
- d  Board and care / assisted living / group home
- e  Homeless (with or without shelter)
- f  Long-term care facility (nursing home)
- g  Hospice
- h  Other: \_\_\_\_\_

**19 GENERAL HEALTH STATUS**

- a Please rate your health: (1)  Excellent (2)  Good (3)  Fair (4)  Poor
- b Have you had any major life changes during past year? (eg, new baby, job change, death of a family member) (1)  Yes (2)  No

**20 SOCIAL/HEALTH HABITS**

- a Smoking:
  - (1) Currently smoke tobacco? (a)  Yes    e  Cigarettes: # of packs per day: \_\_\_\_\_  
 f  Cigars/Pipes: # per day: \_\_\_\_\_
  - (b)  No
  - (2) Smoked in past? (a)  Yes    Year quit: \_\_\_\_\_ (b)  No
- b Alcohol:
  - (1) How many days per week do you drink beer, wine, or other alcoholic beverages, on average? \_\_\_\_\_
  - (2) If one beer, one glass of wine, or one cocktail equals one drink, how many drinks do you have, on an average day? \_\_\_\_\_

**c Exercise:**

- Do you exercise beyond normal daily activities and chores?
  - (a)  Yes    Describe the exercise: \_\_\_\_\_
    - 1. On average, how many days per week do you exercise or do physical activity? \_\_\_\_\_
    - 2. For how many minutes, on an average day? \_\_\_\_\_
  - (b)  No

**21 FAMILY HISTORY (Indicate whether mother, father, brother/sister, aunt/uncle, or grandmother/grandfather, and age of onset if known)**

- a Heart disease: \_\_\_\_\_
- b Hypertension: \_\_\_\_\_
- c Stroke: \_\_\_\_\_
- d Diabetes: \_\_\_\_\_
- e Cancer: \_\_\_\_\_
- f Psychological: \_\_\_\_\_
- g Arthritis: \_\_\_\_\_
- h Osteoporosis: \_\_\_\_\_
- i Other: \_\_\_\_\_

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