

# The Physical Therapy Place

*Orthopedics and Women's Health*

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<b>Name:</b>		<b>Date:</b>	
<b>Date of Birth:</b>		<b>Height:</b>	
<b>Occupation:</b>		<b>Male/Female</b>	
<b>Occupation:</b>		<b>Hobbies:</b>	

**Have your or any immediate family member ever been told you have:**

	Family	You
Cancer	No/Yes	No/Yes
Low/High Blood Pressure	No/Yes	No/Yes
Diabetes	No/Yes	No/Yes
Heart Disease	No/Yes	No/Yes
Angina/chest pain	No/Yes	No/Yes
Stroke	No/Yes	No/Yes
Arthritis	No/Yes	No/Yes

**Do you have a history of:**

Nausea/vomiting	No/Yes
Fever/Chills/Sweats	No/Yes
Unexplained weight change	No/Yes
Numbness or tingling	No/Yes
Muscular weakness	No/Yes
Fainting spells	No/Yes
Dizziness	No/Yes
Night pain	No/Yes
Bowel or bladder changes	No/Yes
Headaches	No/Yes

**Have you had or do you experience:**

Shortness of breath	No/Yes
Allergies	No/Yes
Asthma	No/Yes
Bronchitis	No/Yes
Kidney disease/stones	No/Yes
Polio	No/Yes
Emphysema	No/Yes
Anemia	No/Yes
Rheumatic fever	No/Yes
Ulcers	No/Yes

<b>Have you had any recent illness, including respiratory infections or urinary tract infections?</b>	No/Yes
<b>Do you smoke?</b>	No/Yes If Yes, how many packs a day? _____ How long have you smoked? _____
<b>Do you drink alcohol?</b>	No/Yes How many drinks each day _____ Each week _____
<b>Do you drink/consume caffeine?</b>	No/Yes How often?
<b>How often to you feel stress is a significant factor in your life? (Circle One)</b>	Never Seldom Occasionally Regularly Always
<b>Do you exercise regularly?</b>	No/Yes. If Yes, what type and how often?

**Have you had any surgery? Please list.**

**Please list any medications you may be taking:**