****

**Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s current age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Background/Stated Concerns**

|  |  |
| --- | --- |
| **Why are you here for a PT** **evaluation?** |  |
| **What are your goals for PT:** -Home life, personal hygiene, chores, occupation, athletics, family routine- Pain, endurance, strength, balance, education- Primary areas of focus for PT | 1.2.3.4. |
| **What is difficult for you to do at home, school, work?**Chores, personal hygiene, job? | 1.2.3.4. |
| **How long can you [ ] without pain…** | Stand \_\_\_\_\_\_\_Sit \_\_\_\_\_\_\_Sleep \_\_\_\_\_\_\_Walk \_\_\_\_\_\_\_Drive \_\_\_\_\_\_\_Cook \_\_\_\_\_\_\_Clean \_\_\_\_\_\_\_ |
| **Social/Emotional**Do difficulties affect you socially? How?Emotionally? How? |  |
| **Preferred recreational activities** |  |
| **Occupation**Job requirements that are difficult | 1.2.3. |
| **Are there any precautions or things you have been told by a doctor to avoid?** |  |
| **Do I have your permission** to talk to referring MD, other PT, specialists, take photos (provide details on financial intake) |  |

**PAST Medical history**

|  |  |
| --- | --- |
| **Past medical history of patient:**Broken bones? Surgery? Injury? Accident? Major head strikes with a fall?(may attach extra page if need more room) |  |
| **Past PT/exercise?**  | Did you have PT before?What tried?What worked?What flared pain?When/why stopped? |
| **Current medical diagnoses**  |  |
| **Specialists you have seen & why?** |  |
| **Can you now (or have you ever been able to...** | 1. Can you place your hands flat on the floor without bending your knees?
2. Can you bend your thumb back to touch your forearm?
3. Do your elbows hyperextend “bend the wrong way?”
4. Do your knees hyperextend/“bend the wrong way?”
5. Can you pull your little finger backwards to 90 degrees to the back of your hand?
* As a child, did you amuse your friends with how flexible you were or could you do the splits?
 |

**CURRENT Medical condition for treatment**

|  |  |
| --- | --- |
| **Have you received a diagnosis related to your reason for evaluation? If so, what?** |  |
| **Primary areas of pain (ranked in order of most painful to least)** | 1.2.3.4.5. |
| **What is your pain level out of 10…?** | On a “good” day \_\_\_\_\_\_ /10On an average day \_\_\_\_\_\_ /10On a bad day/flares \_\_\_\_\_\_ /10 |
| **What makes your pain better/worse?** | Better:Worse:  |
| **Have you had dislocations/subluxations? If so, where?** |  |
| **Medications and for what?** |  |
| **Do you have trouble with balance? In what way?** |  |
| **Do you feel “weakness” of your muscles? If so, where?** |  |
| **Do you feel you have issues with:** | GI/stomach/constipation/motility? \_\_\_\_\_\_Memory/concentration? \_\_\_\_\_\_Sleep? \_\_\_\_\_\_ |
| **Do you feel that your endurance is not where it should be? On an “average day” and a scale of 0-10 with 0 being “I don’t even have enough energy to get out of bed” and 10 being “I have no complaints about energy”?** | Average day: \_\_\_\_\_ / 10 |
| **Do you have any neurological symptoms like numbness, tingling, weakness on one side vs other?** |  |
| **What else would you like for me to know?** |  |

**Please return via email (****wendy4therapy@gmail.com****) or fax (630-428-3022):**

* + - 1. **This EDS questionnaire**
			2. **Copy of front and back of insurance card**
			3. **Name and DOB of subscriber**
			4. **Financial/communication agreement (signed)**
			5. **Disability indexes (can bring to appointment)**

**Thank you for taking the time to fill that out. It will make our time together more productive.**

**EDS/hypermobility symptoms**

**Flexibility**

|  |  |
| --- | --- |
| 1, Can you place your hands flat on the floor without bending your knees?2. Can you bend your thumb back to touch your forearm?3, Do your elbows “bend the wrong way?”4. Do your knees hyperextend?5. Can you pull your little finger backwards to 90 degrees to the back of your hand?SCORE* As a child, did you amuse your friends with how flexible you were or could you do the splits?
* Have you had shoulder or kneecap dislocations?
 | Yes/NoRight/LeftRight/LeftRight/LeftRight/Left\_\_\_\_\_\_\_\_Yes/NoYes/No |

**Circle all that apply:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Neurological**MigraineHeadacheDifficulty falling asleepDifficulty staying asleepLight sensitivityConfusionMemory lossDizzinessDifficulty anesthetizingSciatic painPain meds don’t seem to workHypermetabolizer of medsAnxietyDepressionBump into things/clumsyPoor temperature regulationMultiple chemical sensitivitiesMorton’s neuromaDifficulty swallowingADHDTendency toward self harmSuicidal ideationChiariCranial-cerv instability | **Musculo/skeletal**All over body painJoint painFatigue easilyLong, slender fingersFlat feetLong, thin faceHammer toesFrequent sprains/strainsDislocationsDental crowdingTMJHandwriting is difficultOveruse injuriesTendonitisCartilage tearsSprains/strains of ligamentsJoints that clickMuscle spasmsOsteoporosis“Growing pains”Pubic bone painSI joint painNeck painHead feels “heavy”Tendency to brace jointsDifficulty sitting/standing | **Skin**Stretchy skinPoor scar formation “cigarette scar”Keloid scar formationProlonged healing of skin Stitches “don’t hold”Gum recessionBruise easilyFragile skinStretch marksAllergy to tape**Heart/Lungs/Blood** Difficult to get IV/blood drawVaricose veinsPalpitationsDizziness when stand upMiscarriagePremature laborFatigue easily, need to lean or sit | **GI/Digestion**ConstipationGI distressIBSHernias (umbilical, inguinal)Poor gut motilityNauseaHeartburnBloatingAnal prolapseBladder incontinenceBowel incontinenceFood allergies |