Patient Name: _____ DOB: _____

ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

NEUROLOGICAL MEDICAL HISTORY

1. Referring Doctor_____
2. Describe the problem for which you are seeking therapy_____
3. How did the problem start? _____
4. When did the problem start? _____
5. Have you been hospitalized for this and if so, where and when? _____
6. What tests have been done for this problem? (X-ray, MRI etc.) _____
7. **CIRCLE** any of the below that you experience:

   High blood pressure Diabetes High cholesterol Other heart problems

8. Please list any other information regarding your past medical history (including surgeries and diagnoses):

   _____

   _____

EQUIPMENT

16. What kind of equipment do you use?

____Wheelchair ____Walker/type_____ _____Cane

____Bedside commode ____Shower/Bath chair _____Hospital Bed

Other: _____

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LIVING ENVIRONMENT

9. Do you live alone? YES / NO If not, who lives with you? _____

10. Do you receive caregiver assistance? YES / NO If yes, what are the days/hours? _____

11. Do you live in (circle one): Apartment House Mobile Home Other:_____

12. Do you own your home? YES / NO Can you make changes to your home? YES / NO

13. How many floors are in your home? _____

14. How many steps are there to enter your home? Front: _____ Side: _____ Back: _____

15. What type of shower/bath do you have (**CIRCLE**)?

Tub/shower combination Walk-in shower Garden Tub

Separate tub Walk-in Tub

16. Are there any areas that you have trouble accessing in your home? YES / NO

If yes, please explain: _____

DAILY ACTIVITIES

17. Do you drive? _____ If not, how will you get to therapy? _____

18. Are you employed? YES / NO Where? _____ How many hours per week?_____

19. What type of job do you have?_____

20. If you are not currently working, do you plan to go back to work?_____

21. What are your hobbies or activities in your spare time?_____

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22. Please **CIRCLE** any of the below that you are having trouble with:

Bathing/showering	Using the computer/typing	Getting in/out of bed
Feeding yourself	Using the phone	Moving in bed
Dressing	Childcare/pets	Getting out of chairs
Grooming (CIRCLE): teeth, makeup, shaving, washing hands, washing face, or hair	Leisure/hobbies	Walking inside the house
Bladder management	Shopping	Walking outside the house
Bowel management	Driving	Balance
Cooking	Working/Volunteering/School (if currently)	Getting on/off toilet
Nutrition	Medication Management	Falling to the ground
Housework	Finances	Dizziness
Writing	Swallowing	Vision (blurry, double, etc.)
Reading	Talking	Cognition (CIRCLE): memory, problem solving, planning, and/or understanding what is said to you
Other:		

23. What would you like to work on in therapy? _____

_____

_____

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge*.**

Patient Signature: _____ Date: _____

Parent/Guardian's Signature: _____ Date: _____

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