MOSAIC
physical therapy

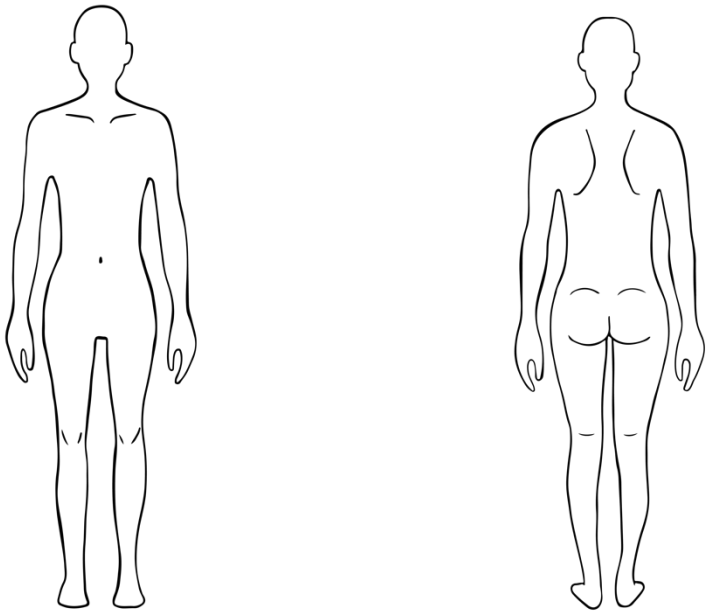
Name: _____ Date: _____

Age: _____ Married___ Widowed.___ Divorced___ Single____

What would you like to accomplish with Physical Therapy?

_____

Please indicate any areas of the body where you are experiencing discomfort. Please indicate severity of discomfort from 1-10 with 1= mild discomfort and 10= severe pain.



Have you had any surgeries? If so, please describe.

Check box to the left of any conditions you have had.

	Stroke		Diabetes
	Cardiovascular disease/heart conditions/chest pain/Atrial fibrillation		Cancer
	Numbness, tingling		Asthma
	Fainting or lightheadedness		COPD
	High Blood Pressure		Broken bones or dislocated joints
	Low Blood Pressure		Osteoporosis
	Headaches		Arthritis

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Other Please describe:_____

Is your physician aware of you participating in a physical therapy program? _____

Do you have any digestion concerns (heartburn, excessive gas, constipation, diarrhea, etc.)?

_____

Are you taking any medications (prescribed or over-the-counter)? If so, please list.

_____

_____

_____

Are you taking any herbs, supplements, or vitamins? If so, please list.

_____

_____

Do you have any significant allergies? If so, please describe.

_____

Do you smoke? If so, how much per day? _____

Do you ever experience shortness of breath or difficulty breathing? Yes____. No____

Please describe your sources and levels of stress (mild, moderate, severe)

_____

What do you do for stress management? _____

How many days/hours a week do you exercise? _____

What type of exercise and for how long per session? _____

How many hours a day do you sleep? _____

What is the quality of your sleep? _____

How is your energy level? Are you fatigued or energetic?_____

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If your quality of life could be improved, which of the following areas would you like to focus on?Select all that apply.

	Reduce pain		Feel a sense of peace
	Improve flexibility		Improve mood
	Improve strength		Improve memory
	Improve Balance		Improve energy
	Improve sleep		Improve ability to concentrate
	Reduce anxiety		Generally feel better

On a scale of 1 to 10, what is your current level of well-being and peace? _____

What would you most like to address for your health and well-being?

Please describe your current functional abilities. Are there any daily activities that you require assistance to safely manage? (Walking, dressing, bathing, changing positions, eating)

_____

_____

Is there anything additional you would like me to know to support you in creating a personalized physical therapy program?

_____

_____

_____

I agree to inform my Physical Therapist of any discomfort or symptoms during our sessions ____(Initial)

I certify that I have read and understand the Physical Therapy Policy and that the above information is accurate and correct.

Signature: _____

Date:_____