BACK into BALANCE
physical therapy

exercise with intention

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NAME: _____

OCCUPATION:

On a daily basis, please estimate:

Time spent sitting _____

Time spent standing _____

Time spent driving _____

Time spent working at a desk/computer _____

Time spent bending _____

Time spent lifting heavy items _____

Please briefly describe your workstation set up, including computer location: _____

Describe your chair: _____

Do you feel supported while sitting: _____

EXERCISE:

How often do you exercise per week frequency and duration:

_____

Please describe your routine prior to injury:

_____

Describe your current routine:

_____

Describe your desired routine:

_____

Please mark the item that best describes your workout preference:

____ Like to work out alone

____ Like to work out with a trainer

____ Like to work out in a class environment

____ Like to work out in the privacy of my home

Please mark the phrase that best describes what motivates you to exercise:

____ Aesthetic results

____ Weight control

____ Reduction of Pain

____ Improved general fitness

____ Improved general health

Please mark how you would best describe your learning style:

____ Auditory learner (hear it)

____ Visual learner (see it)

____ Kinesthetic learner (do it)

____ Intellectual learner (define/understand it)

SYMPTOMS:

Please describe the location of your pain/problem:

_____

Does the pain spread to other areas or does it stay local:

_____

How would you describe the pain (i.e., sharp, burning, achy, dull):

_____

When did the pain begin & what event/activity brought on your symptoms:

_____

What makes your symptoms worse:

_____

What makes your symptoms better:

_____

Please rate your pain on a scale of 0 to 10:
(0=No pain -> 10=Emergency Room-severe pain):

_____

SLEEP:

Please describe your sleep position:

_____

How many pillows do you use:

_____

What is the position of your pillows:

_____

How many hours do you sleep per night:

_____

Do you sleep through the night without awakening: yes no

If you wake during the night, how often do you wake:

_____

How long have you had your current mattress:

_____

Do you flip your mattress at least every 6 months: yes no

SIGNS OF STRESS:

Do you clench or grind your teeth: yes no

Are you a shallow breather: yes no

Do you feel tension between your shoulders and ears: yes no

Do you use a strategy to manage stress: yes no

If yes, what strategies exercise, reading, breathing and relaxation, meditation, other: _____

FUNCTIONAL ASSESSMENT:

Please mark all activities you have difficulty performing:

___ Getting up out of chair

___ Getting in and out of bed

___ Getting up off the floor

___ Going up/down stairs

___ Getting in and out of cars

___ Getting on and off the toilet

Do you use a cane, walker or crutches:

_____

Do you have difficulty with balance: _____

Do you have a history of falls: yes no

If yes, how often have you fallen: _____

Do you have any changes you would like to make home environment to feel safer: _____

Please list any activities of daily living you would like to improve or perform with greater ease:

_____

_____

_____

HOBBIES:

Do you travel often:

_____

What recreational sports to you participate in:

_____

Please list any additional hobbies you enjoy:

_____

What type of music do you enjoy:

_____

SHOE WEAR:

Do you wear custom made or store bought orthotics:

_____

On average what type of sole do you wear: rubber leather other

Describe your average heel height: low medium high

DAILY ROUTINE:

Do you wear glasses: yes no

Do you wear a dental/mouth guard: yes no

Do you follow a specialized diet: yes no

Describe your typical daily routine:

_____

_____

_____

_____

_____

_____

_____

Please list your goals for physical therapy:

_____

_____

_____

_____

_____

_____

_____