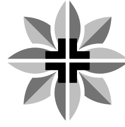


OUTPATIENT THERAPY SERVICES
AMBULATORY SUMMARY LIST

Patient Identification Label

1. Check all the **medical conditions or problems** that apply to you:

☐ Anemia
☐ Arthritis/gout
☐ Asthma
☐ Back trouble
☐ Cancer
☐ Chest pain
☐ CHF
☐ Diabetes
☐ Fainting
☐ Fibromyalgia
☐ Fractures
☐ Head injury
☐ Heart disease
☐ Heart attack
☐ Hepatitis
☐ Hernia
☐ High blood pressure
☐ HIV / AIDS
☐ Kidney Disease
☐ Lupus
☐ Lung problems
☐ Metal/foreign implant
☐ Migraines
☐ Motor vehicle accident
☐ Multiple sclerosis
☐ Neuropathy
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's disease
☐ Psychiatric treatment
☐ PVD
☐ Seizures
☐ Shortness of breath
☐ Stroke
☐ Swelling
☐ Tuberculosis
☐ Thyroid disease
☐ Other: ____________________
☐ Other: ____________________

2. List any **surgeries or procedures** that you have had: ____________________

____

List any previous therapy? ____________________

3. List current **medications**: ____________________

____

____

____

4. **Allergies:** ____________________

5. Do you smoke? ☐ Yes ☐ No   Are you pregnant? ☐ Yes ☐ No

6. Any significant weight gain/loss in the last year? ☐ Yes (+ / -) __________lbs ☐ No

7. What is your occupation? ____________________

8. Reasons for being referred to therapy: ____________________

9. Describe the injury or onset of this condition: ____________________

____________________ Date of onset: __________

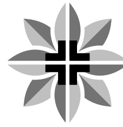
10. Please provide the results of any recent testing, X-rays, MRI, blood work, etc.? ____________________

____

Patient Signature: ____________________ Date: __________

DO NOT WRITE BELOW THIS LINE

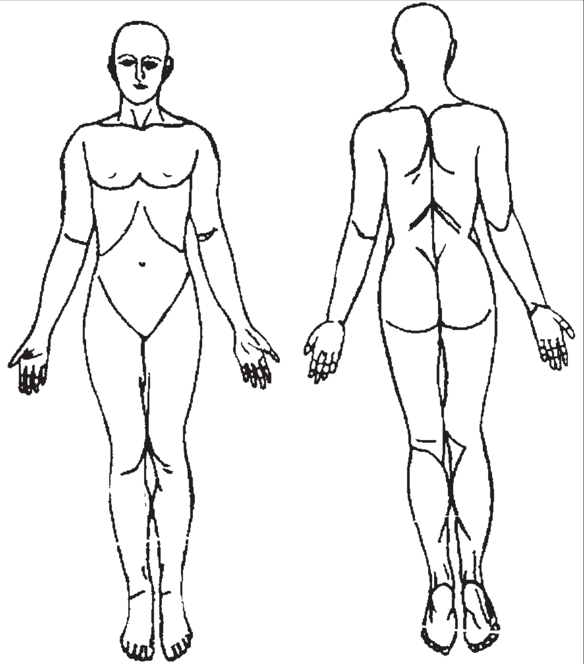
MBMC 7-3343-0491 EF



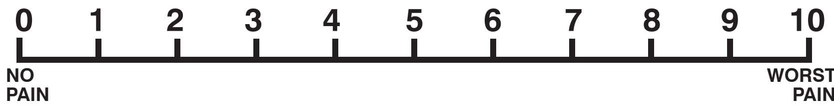
Missouri Baptist
MEDICAL CENTER
BJC HealthCare℠

OUTPATIENT THERAPY SERVICES
AMBULATORY SUMMARY LIST

Patient Identification Label



11. Mark the location of pain on the picture.
12. Type of pain:
    ☐ sharp ☐ burning ☐ aching ☐ tingling ☐ numbness
    Other:____________________
13. Rate your overall pain on the scale:



14. Does pain radiate into arms and legs? ☐ Yes ☐ No
    Does pain awaken you? ☐ Yes ☐ No
15. What aggravates your pain most:
    ☐ sitting ☐ standing ☐ walking
    Other:____________________
16. What positions or activities relieve or decrease your pain:
    ____
17. Does rest relieve pain? ☐ Yes ☐ No
18. Check all the activities that you have difficulty performing:
    ☐ Sleeping
    ☐ Sitting
    ☐ Standing
    ☐ Climbing stairs
    ☐ Driving
    ☐ Running ☐ Jumping
    ☐ Getting in/out of bed, chair, car
    ☐ Leisure/Recreational activities
    ☐ Shopping ☐ Cooking ☐ Cleaning
    ☐ Lifting ☐ Bending ☐ Kneeling ☐ Squatting
    ☐ Pushing ☐ Pulling
    ☐ Personal care (bathing, dressing, grooming)
    ☐ Specific job duties: ____________________
    Other: ____________________
    Other: ____________________
    Other: ____________________
19. What do you expect to gain/accomplish in receiving therapy? ____________________
20. How did you hear about our clinic? ☐ Doctor ☐ Website ☐ Friend ☐ Publication
    ☐ Other:____________________

DO NOT WRITE BELOW THIS LINE