JTOPS
JULIA TEMPLE OUTPATIENT SERVICES

NAME:_____DATE:_____

Height:_____ft_____in Weight: *(approximate)*_____lbs Do you smoke: O No O Yes_____ppd

Are you: O Single O Married O Divorced O Widowed O Other_____

Do you have children? O No O Yes, and they live with me O Yes, and they live in _____

Do you require assistance with Activities of Daily Living? O No O Yes, please check which ones:

ADL	No Help	Some Help	Unable	ADL	No Help	Some Help	Unable
Getting in/out of bed	O	O	O	Putting shoes/socks on	O	O	O
Using the toilet	O	O	O	Bathing/Showering	O	O	O
Dressing upper body	O	O	O	Going up/down stairs	O	O	O
Dressing lower body	O	O	O	Getting in/out of car	O	O	O

Are you: O working full-time O working part time O in vocational re-training O in vocational re-education

O not working O retired *If you are not working, do you desire to return to work?* O Yes O No

*If you are not working, how long have you been off work?*_____wks_____months_____years

Have you ever had a previous work-related injury or illness? O Yes O No *If yes, when?* _____

How many surgeries have you had in your lifetime? O None O Yes I have had surgery. *Please list:*

_____

_____

Do you currently take any medication, including over the counter? O None O Yes *Please list them with dosage*

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

If extra space is needed, please continue on the back.

Place a check mark beside any past or present medical condition.

CONDITION	Present	Past	No	CONDITION	Present	Past	No
Anxiety	O	O	O	High Blood Pressure	O	O	O
Arthritis	O	O	O	HIV / AIDS	O	O	O
Asthma	O	O	O	Hyperthyroidism	O	O	O
Bladder/Urinary Disorder	O	O	O	Hypothyroidism	O	O	O
Cancer	O	O	O	Liver Disease	O	O	O
Chemical or Alcohol Dependency	O	O	O	Lung disease/ emphysema	O	O	O
Chronic Pain	O	O	O	Osteoporosis / Osteopenia	O	O	O
Congestive Heart Failure	O	O	O	Peptic Ulcers / Reflux disease	O	O	O
Heart Disease or Heart Attack	O	O	O	Renal or Kidney Disease	O	O	O
Depression	O	O	O	Seizure Disorder	O	O	O
Diabetes	O	O	O	Stroke	O	O	O
Headaches or Migraines	O	O	O	Tuberculosis	O	O	O
Hepatitis	O	O	O	Vertigo	O	O	O

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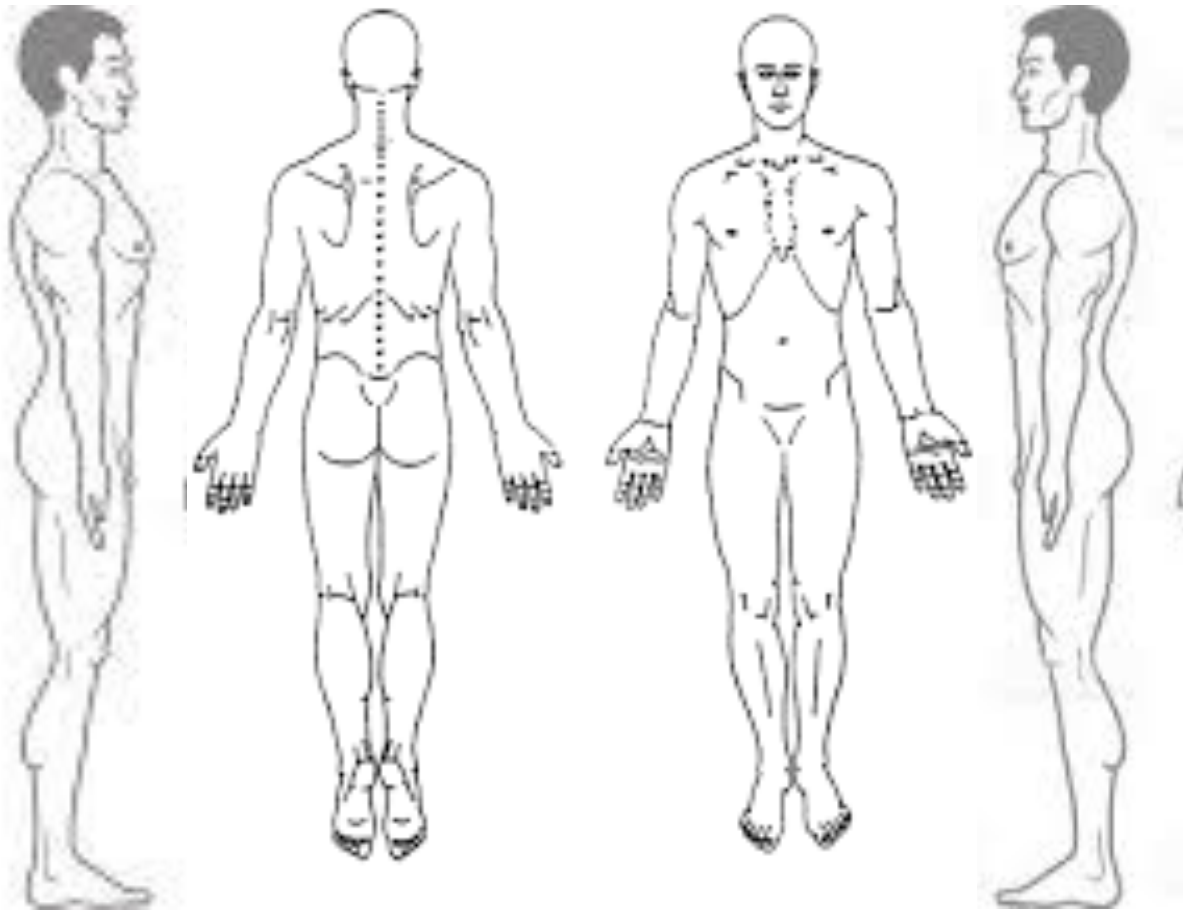
Please indicate below where your symptoms are located. Describe your symptoms beside the body diagram: **A = Aching** **B = Burning** **C = Cramping** **N = Numbing** **S= Shooting** **T = Tingling**



If you described symptoms in more than one area, please list them in order of severity:

1. _____

2. _____

3. _____

Please list up to 3 goals <u>you hope</u> to achieve as a result of your Therapy Program:

1. _____

2. _____

3. _____