## History of Present Illness

### Why are you here today? (Select all that apply)
- a fall/decreased balance
- cancer treatment
- decreased mobility
- fatigue
- pain
- weakness
- a surgery
- decreased endurance
- decreased range of motion
- neuropathy
- swelling

### Additional Comments:

### On what date did this occur?

### Do you have pain? [ ] Yes [ ] No

#### Which side? (Select all that apply)
- left
- right

#### Where is this pain located? (Select all that apply)
- neck
- ankle
- leg
- buttock
- arm
- upper back
- lower back
- mid back
- hand
- foot
- shoulder
- chest
- hip
- genital/groin
- mouth
- throat

#### What makes this pain worse? (Select all that apply)
- twisting
- sitting
- prolonged sitting
- overhead reaching
- sidelying
- chewing
- squatting
- walking
- bending
- repetitive movement
- lying on back
- medication

#### What makes this pain better? (Select all that apply)
- nothing
- rest
- immobilization
- sitting
- heat
- pain medication
- bracing
- elevation
- standing
- walking

#### How would you describe this pain? (Select all that apply)
- dull
- sharp
- aching
- throbbing
- shooting
- constant
- intermittent

### Have you had any diagnostic tests done? [ ] Yes [ ] No

#### If yes, select all that apply.
- Xray
- MRI
- CT
- PET scan
- stress test
- bone scan
- doppler/US
- ankle brachial index

### Do you currently have numbness and tingling?  [ ] Yes [ ] No

#### If yes, where? (Select all that apply)
- right arm
- left arm
- right leg
- left leg
- trunk/chest

### Additional Comments:
Are you getting chemotherapy?  □ Yes  □ No
If yes, how often?  

Are you having any side effects from chemotherapy?  □ Yes  □ No
If yes, what are they?

Date Started?  □  Date Completed?  □

Have you been diagnosed with chemotherapy induced peripheral neuropathy?  □ Yes  □ No
If yes, are you experiencing difficulty with any of the following? (Select all that apply)
□ fastening buttons  □ sleeping
□ negotiating stairs  □ loss of balance
□ falling  □ typing on a keyboard
□ dressing  □ writing
□ walking  □ using eating utensils
□ other

Additional Comments:  

Are you getting radiation treatment?  □ Yes  □ No
If yes, where?

Date Started?  □  Date Completed?  □

Do you use oxygen?  □ Yes  □ No

Amount Used?  □ 1 liter  □ 2 liters
□ 3 liters  □ 4 liters
□ > 4 liters

Frequency of Use?  □ intermittently  □ continuously
□ nightly

Have you experienced an unintended weight loss?  □ Yes  □ No
If yes, how many pounds and in what time period?

Have you experienced an unintentional weight gain?  □ Yes  □ No
If yes, how many pounds and in what time period?
### Home Environment

**How would you rate your health?**
- [ ] excellent
- [ ] good
- [ ] fair
- [ ] poor

**Do you exercise regularly?**
- [ ] does
- [ ] does not

**How many falls have you had in the past 6 months?**
- [ ] 0
- [ ] 1 to 2
- [ ] >3

**Do you use a walking aid?**
- [ ] Yes
- [ ] No

If yes, what? (Select all that apply)
- [ ] cane
- [ ] walker
- [ ] rollator
- [ ] wheelchair
- [ ] crutches

**What is your employment status?**
- [ ] employed
- [ ] unemployed
- [ ] retired

What do you do for a living?

**Do you live alone?**
- [ ] alone
- [ ] with someone

If you live with someone, in which setting do you live?
- [ ] assisted living facility
- [ ] nursing home
- [ ] group home
- [ ] private residence with caregiver/family

**Do you require assistance at home?**
- [ ] Yes
- [ ] No

**Do you have stairs at home?**
- [ ] Yes
- [ ] No

If yes, how many?
- [ ] 1-8
- [ ] 9-15
- [ ] >15

Where is the railing as you go up the stairs? (Select all that apply)
- [ ] left
- [ ] right

### Goals/Followup

**What are your goals for therapy?**

**When are you scheduled to return to the doctor for follow-up?**
- [ ] as needed
- [ ] within 1 month
- [ ] after completion of therapy

**Additional Comments:**