Coach House Physical Therapy

INITIAL INTERVIEW FORM

Name: _____ Date: _____
Address: _____ Phone: _____
Emergency contact: _____ Phone: _____
Age: _____ Sex: _____ Occupation: _____
Height: _____ Weight: _____ Highest Level of Education: _____
Marital Status: _____ Advance Directives: _____
Diagnosis: _____ Insurance Provider: _____
Referring Physician: _____
Primary Care Physician: _____
Referral Source: _____
Chief Complaint: _____

History

How many times have you been hospitalized in the last year due to lung problems?_____
# of days in the hospital in the last year due to lung disease? _____
How many E.R. visits have you had in the past year as a results of breathing difficulty?_____
Last hospital admission: _____ Release: _____
Previous hospitalizations: _____
Have you ever attended a pulmonary rehabilitation program? _____
Have you ever had any chest injuries or surgeries? Yes / No
Type _____
Do you have upcoming surgeries? Yes / No
Do you have any physical limitations that may affect your ability to exercise (sensory loss, amputation, stroke, surgeries, fractures, etc.)? _____
Do you have any other medical problems? _____
Cardiovascular disease _____
Hypertension _____
Diabetes _____
G-I problems _____
Reflux/hiatal hernia _____
Osteoporosis _____
Sinusitis _____
Vision or healing problems _____
Other _____

Have you ever had or do you have:

Emphysema	_____	Valley fever	_____
Asthma	_____	Tuberculosis	_____
Bronchitis	_____	Pleurisy	_____
Pneumonia	_____	Lung cancer	_____
Bronchiectasis	_____	Sinus trouble	_____
Blood clot in lung	_____	Other	_____
High pressure in lungs	_____		

(continued)

Do you have a family history of respiratory disease? _____
Have you ever used tobacco? _____ What form? Chew/Smoke _____
Do you chew/smoke now? _____ How long did/have you used tobacco? _____
When did you stop chewing/smoking? _____
If you are still smoking, do you plan to quit? _____
Do you live with any smokers? _____
Other substance abuse? _____
Have you ever been exposed to:

Asbestos dust	Yes/No	Paint fumes	Yes/No
Cotton dust	Yes/No	Plastic fumes	Yes/No
Mining dust	Yes/No	Solvent fumes	Yes/No
Other dusts	Yes/No	Other fumes	Yes/No

Do you consume alcohol? _____ How much? _____
Do you have an allergies (food, pollen, drugs, etc.)? _____
How many colds do you get per year? _____
Vaccines: Flu Yes/No Pneumonia Yes/No
Do you ever have chest pain? _____ Location _____
Type of pain _____ Frequency _____
Have you ever had a heart attack? _____ When? _____

Major Symptomatology

What are your symptoms? _____
What were your symptoms last year? _____
What were your symptoms five years ago? _____
When did you realize that you had lung problems? _____

Disease Impact

Do you sleep flat or with your head elevated? _____
If elevated, how high? _____
Do you awaken during the night? _____ How often? _____
Why? _____
Do your ankles ever swell up? _____ When? _____
Do you cough? _____ What part of the day? _____
Do you cough up sputum? _____ When? _____
Describe _____
Have you ever coughed up blood? _____

Dyspnea Index

_____ Class 1: If SOB, consistent with activity
_____ Class 2: SOB climbing hills or stairs
_____ Class 3: Can walk at own pace but not at normal pace without SOB
_____ Class 4: SOB walking 100 yards on level ground, dressing, or talking

Do you use oxygen? _____ How often? _____ LPM: _____
Type of oxygen delivery system _____ Supplier _____
Are you on any home respiratory therapy? _____ Type _____
Do you use any respiratory equipment? _____ Type _____
How do you clean the equipment? _____

(continued)

Do you have trouble eating? _____ Why? _____
Do you have trouble gaining or losing weight? _____

Have you experienced a recent weight change? _____
Do you have a special diet? _____
Are you able to care for yourself? _____
Are you able to take care of your home? _____
Do you exercise? _____ If yes, how? _____ How often? _____
Do you have exercise equipment? _____ Type _____
Has your physician limited your activities? _____
Any special interests or hobbies? _____
What activities doe your breathing difficulty prevent you from doing that you would like to do? _____
Does your breathing interfere with your ability to have sexual relations? _____
Are others close to you affected by your health? _____
If yes, how? _____
Are you affected by trying to live up to others' expectations? _____
How? _____
Do you find yourself worrying daily? _____ occasionally? _____ almost never? _____
Does your income cover your expenses and needs? _____
Do you live alone? _____
Do you have transportation? _____ How? _____
How do you heat and cool your home? _____
Do you have any pets? _____

Medications

Type	Amount	Frequency