



Patient Medical History & Status

Name: _____ Date of Birth: ____/____/____ Age: _____

Is this injury related to an Auto Accident? Yes No

Did this injury happen while at Work? Yes No

Do you have a current Workers Compensation Claim Open? Yes No

I am: Male Female

I am living: Alone Alone but with assistance for my needs
 With an adult person(s) With children in home, ages _____

I am currently: Employed; my job is _____
 I am on a sick leave I am on disability Applying for disability
 I am unemployed I am retired I work inside the home

My physical activities include:

- Reading, watching TV
- Walking, gardening, housework, occasional physical exercise
- Regular physical exercise at least twice per week

I began having pain/symptoms on or about: ____/____/____

I have had this condition: Never until now Once Many times before

What activities and/or activities make your pain worse? (circle below)

Sitting Standing Walking Bending Stairs Transfers Squatting Bending Kneeling Driving Lying Down
Reaching Overhead Reaching behind back Lifting Objects Dressing Cooking Cleaning Gripping objects

Other: _____

What eases your pain? (circle below)

Ice Heat Rest Stretching Therapy Medication Lying down Standing Sitting Bending

Other: _____

Have you had/or scheduled for diagnostic imaging (i.e. X-ray, MRI, Nerve conduction study, etc.)?

Explain: _____

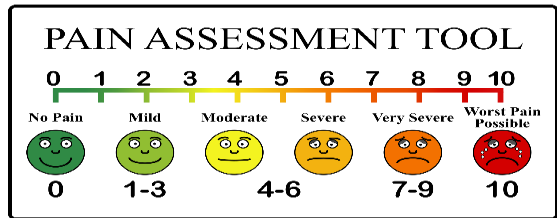
Are you able to perform any activities that you were not able to before starting physical therapy? Yes No

Explain: _____

Have you ever had Physical Therapy before? Yes No

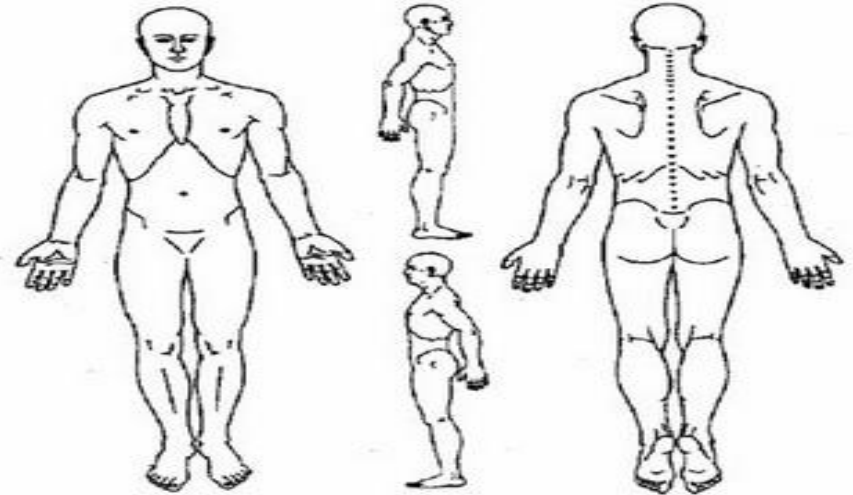
Please rate your pain level using the tool provided:

At Worst: _____/10
 Current: _____/10
 Best: _____/10



Please Mark the area of pain or discomfort on the chart provided, using the appropriate symbols:

Burning: ^ ^ ^ ^ ^
 Sharp: + + + + +
 Dull/Achy: X X X X X
 Throbbing: : o o o o o
 Shooting: → → →
 Numbness/Tingling : =====



My Pain is: Constant Intermittent

Are you currently taking any Medication(s)?
 Yes No

List current medication(s) Please include Dose/Frequency (or provide list):

Currently, I am experiencing the following (check all that apply):

<input type="checkbox"/> Unexplained Weight Loss	<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Increased Pain at Night	<input type="checkbox"/> Headaches	<input type="checkbox"/> Changes in Bowel/Bladder Function
<input type="checkbox"/> Fever / Chills / Sweats	<input type="checkbox"/> Nausea / Vomiting	<input type="checkbox"/> Depression
<input type="checkbox"/> Changes in Appetite	<input type="checkbox"/> Numbness / Tingling	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Difficulty Swallowing	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Other: _____

Have you fallen over the past 12 months? Yes No If yes, how many times? _____

Have you ever had any surgery? Yes No

Date of Surgery: ____/____/____

Type of Surgery: _____

Past Medical History: Do you now have/or have you ever had any of the following conditions? (Circle all that apply)

<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> History of Cancer
<input type="checkbox"/> Cardiovascular Disease	<input type="checkbox"/> Huntington's
<input type="checkbox"/> Cauda Equina Syndrome	<input type="checkbox"/> Immunosuppression
<input type="checkbox"/> Stroke	<input type="checkbox"/> Lupus
<input type="checkbox"/> Current Infection	<input type="checkbox"/> Muscular Dystrophy
<input type="checkbox"/> Diabetes type 1	<input type="checkbox"/> Obesity
<input type="checkbox"/> Diabetes type 2 (adult onset)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Fracture or suspected fracture	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Traumatic Brain Injury
<input type="checkbox"/> Other : _____	<input type="checkbox"/> Pacemaker

During the past month, have you often been bothered by feeling down, depressed or hopeless? Yes No

During the past month, have you often been bothered by little interest or pleasure in doing things? Yes No

What activities are you having difficulty doing because of your pain or dysfunction?

What is your personal goal for Physical Therapy?

Is there any other information or concerns you would like to share with your therapist?

Patient Name (Printed): _____

Date: ____/____/____

Patient/Guardian Signature: _____

To our patients: Although many of these questions may not seem relevant to your visit today, we ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal injuries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for your overall wellbeing and health.

For therapist use:

Self-reported or functional index score: _____/_____

Oswestry Cervical Index DASH LEFS DHI FOTO Other: _____

Therapist signature

Date