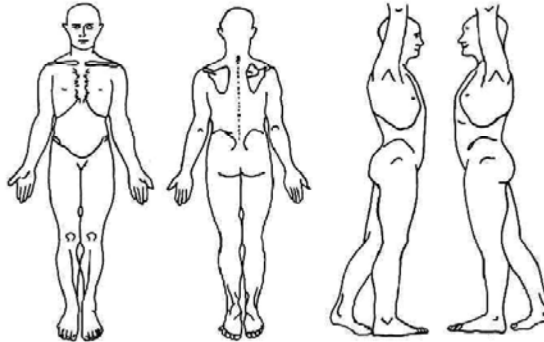
Patient History

Date: _______________

Name: ____________________________________ Gender: Male ☐ Female ☐ Age: ____ Date of Birth: ______________

Occupation: ___________________________ Are you currently working? Yes ☐ No ☐ Full-time ☐ Part-time ☐ Student ☐

Current Symptoms: Please mark your affected area on the diagram using: XXXX = pain, 0000 = tingling/numbness



Date of Onset/Injury (MM/DD/YYYY): ____/____/____ Briefly describe how and when you current symptoms began: ____________

____

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Are you currently being treated by:

Another Therapist:	Yes ☐ No ☐	Or within the last 12 months?	Yes ☐ No ☐
Chiropractor/ Osteopath:	Yes ☐ No ☐	Or within the last 12 months?	Yes ☐ No ☐
Home Health Agency:	Yes ☐ No ☐	Or within the last 12 months?	Yes ☐ No ☐

Date of last MD visit pertaining to current injury: _________________ Next scheduled visit with referring MD: ________________

Have you had any previous injury or surgery to this related region: Yes ☐ No ☐

If yes, please explain and provide dates: ____

Medical History: Please check if you have ever had (check all that apply):

☐ Dizziness ☐ Numbness ☐ Circulation Problems ☐ Gout ☐ Cancer (location ___________)
☐ Diabetes ☐ Pacemaker ☐ Currently Pregnant ☐ Allergies ☐ Tumors (location ___________)
☐ Seizures ☐ Arthritis ☐ Heart Disease ☐ Heart Attack ☐ Cardiac Condition (explain __________)
☐ Osteoporosis ☐ Hernia ☐ Shortness of Breath ☐ Stroke ☐ Neurological Disorders (i.e. MS, ALS)
☐ Headaches ☐ Loss of Balance ☐ Infectious Disease ☐ High or Low Blood Pressure
☐ Metal Implants ☐ Difficulty Sleeping ☐ Pain with Cough/Sneeze ☐ Bowel/Bladder Changes
☐ Peripheral Vascular Disease ☐ Asthma ☐ Other (explain ____________)

Major surgeries since birth (date/procedure): ____

____

Continued on Back

Name: ____

Has your physician placed you on any work restrictions/precautions? No ☐ Yes ☐, Please Explain: ____________________________

Please list current medications, including dosage: ____

____

Diagnostic Testing: ☐ X-ray ☐ MRI ☐ CT ☐ NCV ☐ Other Known findings: ___________________________________

Allergies to Adhesive: Yes ☐ No ☐ Allergies to Lotions: Yes ☐ No ☐ Other Allergies: Yes ☐ No ☐ (explain _____________)

Current symptoms **improve** with (check all that apply):

☐ Cold/Ice ☐ Heat ☐ Massage ☐ Medication ☐ Standing ☐ Sitting
☐ Lying ☐ Squatting ☐ Bending ☐ Walking ☐ Other (explain ____________)

Current symptoms are made **worse** with (check all that apply):

☐ Sitting ☐ Sports/Hobbies ☐ Walking ☐ Housework (explain ______________)
☐ Yard work ☐ Computer work ☐ Reaching overhead ☐ Driving (explain _____________)
☐ Lifting ☐ Other (explain _______________)

Pain Description: (Check all those applicable):

☐ Constant ☐ Burning ☐ Sharp ☐ Achy ☐ Tingling ☐ Radiating (location _________)
☐ Dull ☐ Stiff ☐ Tight ☐ Numb ☐ Throbbing ☐ Intermittent

Pain Intensity: Rate your pain by marking an 'X' on the following scales:

At Best: 0 +---+---+---+---+---+---+---+---+---+---+ 10
No Pain Worst Pain Imaginable

At Worst: 0 +---+---+---+---+---+---+---+---+---+---+ 10
No Pain Worst Pain Imaginable

Goals: What are your goals and expected outcomes for physical therapy? ____

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Patient Signature Date