

Physical Therapy Patient History

Name _____

Today's Date _____

Age _____ Height _____ Weight _____ Sex: Male/Female Handedness: Right/Left

Occupation _____

Are you currently off work because of this problem? Yes No Light duty

Diagnosis _____ Referral source _____

When did your problems begin? _____

How did your problems begin? _____

Rate your pain: No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

Draw your pain:

- Describe your pain: Dull Ache
 Sharp Stabbing Pins & Needles
 Shooting Pain Burning Throbbing
 Twinge Numbness/Tingling
 Other _____

Is your pain constant? Yes No

Intermittent? Yes No

Fluctuates with activity? Yes No

Wakes you up at night? Yes No

What makes your symptoms worse?

- Sitting Standing Walking
 Lifting Bending Lying down
 Squatting Stress Other _____

Are you ever totally pain free? Yes No

What makes your symptoms better? Sitting Standing Walking Lifting

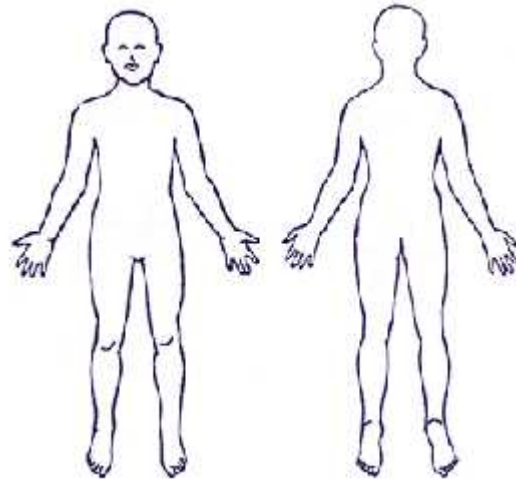
Bending Lying down Other _____

What time of day are your symptoms worst? _____ Best? _____

Do you feel you are: Getting better Getting worse Staying the same

Have you had this problem before? Yes No

If yes, when and how did it get better? _____



Any previous treatment for your current condition? Yes No

Have you had diagnostic studies for your current condition? (X-ray, MRI, CT scan...)
 Yes No

Any other orthopedic problems? Yes No

If yes, please explain: _____

Any medical problems? Yes No

If yes, please explain: _____

Any surgeries? Yes No

If yes, please explain: _____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition: _____

Have you ever had a history of any of the following? Major injury to head/spine
 Cancer/tumors Osteoporosis Dizziness/blackouts Heart problems/angina
 Diabetes Pacemaker Sudden weight loss/gain Severe pain at night
 Smoking Bruising easily Asthma Frequent falls Loss of bowel/bladder control
 Numbness Seizures/epilepsy High blood pressure Coordination loss

Does your current condition limit you in carrying out job duties? Yes No

Household duties? Yes No

What are your goals in physical therapy? _____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.