Patient's History of Current Injury/Illness

Name: ____ **Today's Date:** ________________

Age: _____ **Date of Birth:** ___________ **Sex:** _____ **Marital Status** ______

Occupation: ________________________________ **R- handed** ____ **L-handed**____ **Ht.**______ **Wt**___

Have you ever been a patient here before? Yes_____ No_____; If yes, for the____same or ____different problem?

Please indicate for which body region you are seeking treatment:

__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/wrist __Hip __Knee __ Ankle/foot __ Other

When did your symptoms start? Date _________ Can you identify a cause for your symptoms? Yes____ No _____

If yes, specify: ____

____

Have you ever had similar symptoms in the past? Yes ____ No ____ If **yes**, when?________________________

____

Have you recently had the following tests? Yes ____ No____ If **yes**, check all that apply:

____x-rays ____Bone Scan ____Myelogram ____ EKG
____CT Scan ____EMG ____Stress Test ___Echocardiogram
____MRI ____Blood Tests ____Pulmonary Function Test ____Other (Please list)________________

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

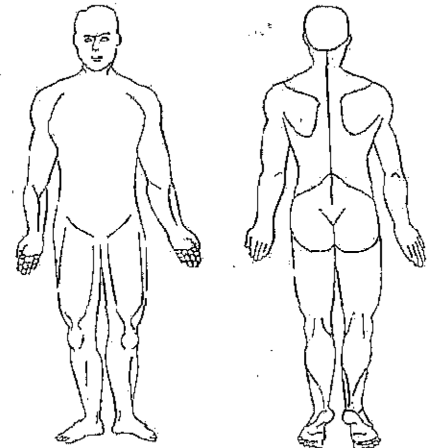
Pain free *Unconscious Pain*

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)

____

____

____



Is the pain there all the time (constant)? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

____

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: ____

Please use the body diagram above and *Shade Areas of Pain*

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes___No___

Describe ____

What activities/positions make your pain worse? ____

____

____

What activities/positions make your pain better?____

____

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Have you previously seen any other health care provider for this problem? ____ Yes ____No

___Physician ___Osteopath ___Podiatrist ___Other (Please list below)

___Physical Therapist ___Chiropractor ___Dentist ______________________________

Are you currently seeing any other health care provider for this condition? ____Yes ____No; If Yes, please list:

____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ___ If yes, please describe: ______________________________

Please circle those treatments listed below that have been tried in the past:

___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Tens Unit ___Injections

___Medications ___None ___Other (please describe):______________________________

RATING SCALE: For each activity listed below, please **CIRCLE** your ability using the ability scale (or mark not-applicable **N/A**)

Activity/Function/Skill	1- Without Difficulty	2- Little Difficulty	3- Moderate Difficulty	4- Much Difficulty	5- Unable to do	N/A
Rolling over in bed	1	2	3	4	5	
Transfer to/from bed	1	2	3	4	5	
Transfer from bath/shower	1	2	3	4	5	
Bathing/Showering	1	2	3	4	5	
Dressing	1	2	3	4	5	
Grooming	1	2	3	4	5	
Balancing	1	2	3	4	5	
Sitting	1	2	3	4	5	
Kneeling	1	2	3	4	5	
Stooping/squatting/bending	1	2	3	4	5	
Standing	1	2	3	4	5	
Walking	1	2	3	4	5	
Stair climbing	1	2	3	4	5	
Lifting	1	2	3	4	5	
Reaching- level/overhead	1	2	3	4	5	
Carrying	1	2	3	4	5	
Transfer to/from car	1	2	3	4	5	
Driving	1	2	3	4	5	
Sleeping	1	2	3	4	5	
Meal preparation	1	2	3	4	5	
Household cleaning	1	2	3	4	5	
List Other Activities Affected by your symptoms (i.e. sports, hobbies, etc.)						
	1	2	3	4	5	
	1	2	3	4	5	

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Medical History

Past Medical History (Illnesses and/or Injuries) **(Please Circle)**

1. Fractures or Joint Injuries
2. Backache or Neckache
3. Arthritis or Gout
4. Heart Disease
5. Stomach, Bowel or Liver Disease
6. Nervous or Mental Disease
7. Diabetes
8. Lung Disease, Emphysema, Asthma
9. Stroke
10. Circulation Disorder (HBP)
11. Cancer
12. Skin Disease
13. Kidney or Bladder Dx
14. Other________________________

Past Operations (and Approximate Dates)

1. Bone or Joint_____________
2. Stomach or Bowel__________
3. Gall Bladder______________
5. Lung__________________
6. Heart or Blood Vessel_____________
7. Kidney, Bladder Prostate__________
8. Hernia______________
9. Appendectomy__________

Medication	Dosage	Reason for Taking

Use additional sheet if more space is needed

Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

__ Private Home __Private Apartment __Rented Room __Group Home __Assisted Living __Skilled Facility __Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): ____________

____

What are your goals for your course of physical therapy? ______________________________

____

At the present time, would you say your health is excellent, good, fair, or poor?_____________

______________________________________ ________________

Patient Signature Date

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