Date: _____ Name: _____

DOB: _____ Acct: _____

Insurance: _____

Patient Health History and Information

Age: _____ **Height:** _____ **Weight:**_____ **Sex:** M F **Pronoun:** He/Him She/Her They/Them

Dominant hand: R L **Could you be or are you pregnant:** Yes No

Reason for Therapy:_____

Date of injury/onset of symptoms: ___/___/___ **Surgery for this condition**: Yes/ No Date ___/___/___ Type _____

Please describe how your injury/problem occurred:_____

Please list any treatment you have received for this condition(ie. PT, chiro)_____

For this condition have you had any of the following? EMG___/___/___ X-ray ___/___/___ MRI / CT scan ___/___/___

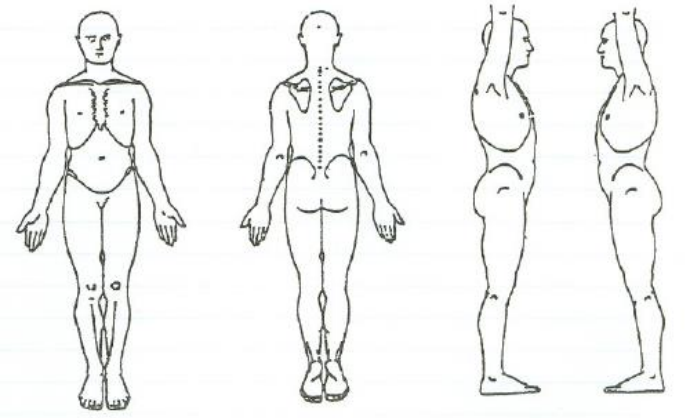
Injection: type: _____ ___/___/___ Other:_____ ___/___/___

Have you had this problem before? Y/N When?_____ What kind of treatment?_____

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain **//**= Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing		Increasing		Staying the same	
Weakness	Giving way	Throbbing	Other:_____		

What makes your symptoms worse? _____

What makes your symptoms better? _____

Limitations due to your current problem:_____

____Laying down	____Bending	____Turning Head	____Sleep/Awake from Pain
____Sit to stand	____Work	____Sitting	____Self Care/Hygiene
____Up/Down Stairs	____Driving	____Walking	____Home activities
____Squatting/Lifting	____Swallowing	____Standing	____Repetitive activities
____Looking overhead	____Talk/Chew/Yawn/All	____Reaching	____Sport/Recreation
____Taking a breath	____ Cough/sneeze pain	____Child care	

What are your goals for therapy? (Two things you want to be able to do again or do better)

1._____ **2.** _____

How did you hear about Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

GENERAL HEALTH HISTORY:

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other:_____	Yes	No
Headaches	Yes	No			

Have you had any falls or near falls in the past year? Yes/No. If yes, how many _____

Rate your overall health: Excellent Good Average Poor **Living Situation:** Alone Spouse Family Others

Do you exercise? Yes / No _____x/week Type:_____ **Do you smoke?** Yes/ No **Do you drink caffeinated beverages?** Yes/No ___/week

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Anxiety	Self	Family	No	Thyroid problems	Self	Family	No
Cancer	Self	Family	No	Epilepsy/dizziness	Self	Family	No
High Cholesterol	Self	Family	No	Tuberculosis	Self	Family	No
High blood pressure	Self	Family	No	Anemia/blood disorder	Self	Family	No
Heart trouble/angina	Self	Family	No	Multiple Sclerosis	Self	Family	No
Diabetes	Self	Family	No	Circular/vascular problems	Self	Family	No
Stroke	Self	Family	No	Chemical dependency	Self	Family	No
Osteoporosis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Osteoarthritis	Self	Family	No	AIDS/HIV	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Hepatitis	Self	Family	No
Depression	Self	Family	No	Bladder/bowel problems	Self	Family	No
Headaches	Self	Family	No				
COVID-19	Self	Family	No	Other:_____			

SURGICAL HISTORY (please list any surgeries): _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: No _____ Yes _____

WORK HISTORY:

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____

Employer:_____ **Current work duty:** Full duty Restricted duty **Work days missed:** _____

QRC and/or Adjuster (if you have one)**:**_____

Patient Signature: _____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last Medical history completion (date and initial any changes)

– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:_____ **Date** ____/____/____

Reviewed by Therapist: _____ **Date** ____/____/____