PATIENT HISTORY FORM

Date: _____
Name: _____
Height: _____ Weight: _____

PRESENT INJURY

Please specify the body region(s) involved for which you are seeking physical therapy (i.e. left knee, right hand)
_____

Date of Injury or Estimated Date of Onset: _____

Have you received previous treatment for this condition? Yes No If yes, please circle all that apply:
Medicine Injections Surgery Chiropractic Physical Therapy Other: _____

Severity of your pain? Mark the point on the line, 0(least) and 10(worst) which best describes your current pain level.

0 1 2 3 4 5 6 7 8 9 10

SOCIAL HISTORY

Do you smoke?: No Yes

MEDICAL HISTORY

Medications: Please circle medications that you are currently taking:

Pain Anti-inflammatory Blood Thinner Blood Pressure Meds

Surgeries: Please list pertinent past surgeries and dates:
_____
_____

Allergies: List all allergies (medications, tapes, latex, etc.)
_____

Fall Risk: Have you had any loss of balance or falls in the past 12 months? No Yes How many? _____

Please circle *Yes* or *No* if you have any of the following conditions? If yes, please explain.

Constitutional:
Recent weight changes N Y _____
Night sweats, pain, fevers N Y _____

Cardiovascular:
Chest pain/heart trouble N Y _____
High/low blood pressure N Y _____
Pacemaker N Y _____

Respiratory:
Chronic Obstructive Pulmonary Disease (COPD) N Y _____
Asthma N Y _____

Musculoskeletal:
Muscle pain/cramps N Y _____
Muscle weakness N Y _____
Stiffness/swelling joints N Y _____
Rheumatoid arthritis/Joint pain N Y _____
Fibromyalgia N Y _____

Endocrine:
Diabetes N Y _____

Genitourinary:
Females: Could you be pregnant? N Y_____

Gastrointestinal:
Nausea/vomiting N Y _____
Abdominal pain N Y _____

Neurological:
Convulsion/seizures N Y _____
Numbness/tingling N Y _____
Head/spinal injury N Y _____
Dizziness N Y _____

Psychiatric:
Confusion/memory loss N Y _____

Other:
Cancer N Y _____
HIV-AIDS N Y _____
Hepatitis N Y _____