Patient History

Name____ Male_____ Female_____ Date ____________________

Age_______ Height_________ Weight _______ Occupation____

CHIEF COMPLAINT AND PRESENT ILLNESS

Area of injury/symptoms______________________________ Date your symptoms/ injury started:_______________

Diagnosis from your doctor:____________________________ Date of your next doctor recheck:_________________

Primary reason for attending therapy? *(circle)*

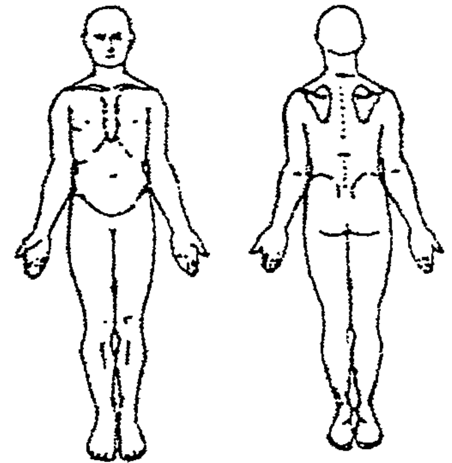
1) Pain
2) Limited motion
3) Weakness
4) Activity reduction
5) Loss of independence
6) Unable to work
7) Unable to do household tasks
8) Unable to play sports or do recreation

Are you currently off work because of this problem____no _____yes. If yes, last day worked________________________

How did your symptoms start?____

How would you describe your problem?____

Using the diagram circle the specific area of pain. If pain travels draw arrows.



Please RATE your pain level. No pain 1 2 3 4 5 6 7 8 9 10 Worst pain

How would you DESCRIBE your pain?

Dull ache____	Burning_____	Heavy____	Sore_________
Deep ache___	Throbbing___	Twinge___	Other________
Stabbing____	Squeezing___	Cramp____	_____________
Nagging_____	Drawing____	Sharp_____	_____________

Do you have any numbness/ tingling?______________________________
Where?____

Prior to this onset were you free of these symptoms? Yes___ No____
Explain:____

What eases the pain?____

What aggravates the pain?____

Have you had any other treatment for this problem?______ If so, what?____

Did it help?________ Do you feel you are getting better, getting worse or staying the same? *(circle one)*

Please list diagnostic imaging or tests and relevant findings:____
____
____
____

HEALTH HISTORY

Musculoskeletal
__ Bone or joint disease
__ Tendonitis/Bursitis
__ Arthritis/Gout
__ Jaw Pain (TMJ)
__ Lupus
__ Spinal Problems
__ Migraines/Headaches
__ Osteoporosis

Circulatory
__ Heart Condition
__Phlebitis/Varicose Veins
__Blood Clots
__High/Low Blood Pressure
__ Lymphedema
__ Thrombosis/Embolism

Respiratory
__Breathing Difficulty/Asthma
__ Emphysema
__ Allergies, specify:
____
__ Sinus Problems

Nervous System
__ Shingles
__ Numbness/Tingling
__ Pinched Nerve
__ Chronic Pain
__ Paralysis
__ Multiple Sclerosis
__ Parkinson's Disease

Reproductive
__ Pregnant, due date: ______________
__ Ovarian/Menstrual Problems
__ Prostate

Skin
__ Allergies, specify:
____
__ Rashes
__ Cosmetic Surgery
__ Athlete's Foot
__ Herpes/Cold Sores

Digestive
__ Irritable Bowel Syndrome
__ Bladder/Kidney Ailment
__ Colitis
__ Crohn's Disease
__ Ulcers

Psychological
__ Anxiety/Stress Syndrome
__ Depression

Other
__ Cancer/Tumors
__ Diabetes
__ Drug/Alcohol/Tobacco Use
__ Contact Lenses
__ Dentures
__ Hearing Aids

Any other medical condition(s) not listed:_______________
____
____
____

Please explain any of the conditions that you have marked above:
____
____
____
____

GENERAL HEALTH

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you here, please describe for what reason:____
____

Please list any surgeries, hospitalizations, emergency care, or injuries. Include the approximate date and reason.

DATE:	Reason:
____________________	______________________________________
____________________	______________________________________
____________________	______________________________________

Have you experienced any of the following since the onset of your symptoms ? *(Check all that apply)*

__Change in energy level __fever/night sweats __ shortness of breath __chest pain __Skin/nail changes
__Bowel/bladder changes/dysfunctions __palpable growing mass

Please describe your current HEALTH HABITS:
Has your appetite changed in the past 3 months_____ or 2 years_____? Any unexplained weight loss_____?

How often do you take time for exercise? __Daily __3-4 days per week __1-2 days per week __less than once per week
What exercise do you do?____
____

MEDICATIONS

Please list ALL PRESCRIPTION AND OVER THE COUNTER medications used in the past week for this and any other condition (*including pills, injections, and/or skin patches)*:
____
____
____
____

Name:______________________________________ Date:____________________