PATIENT HISTORY

1 PATIENT CONDITION

Date: _______________ Birthdate: ____________
Patient Name: ____________________________
Physician: ______________________________
Date of next appointment: ___________________

Is condition due to an accident? ☐ Yes ☐ No
If yes, what was the date of Injury: _____________
When did your symptoms appear?
____
Is the condition getting progressively worse? _____
Have you had this injury/symptoms before? ______
____
Have you had any surgery related to this problem?
☐ Yes ☐ No If yes, give date and details:
____
Occupation: ______________________________
Are you currently working? ___________________
Are you under any restrictions? Please list them?
____
What limitations do you now have due to this condition in your day to day activities? __________
____
Please describe your personal goals in attending physical therapy: __________________________

2 PATIENT TREATMENTS

Have you had any other treatments for this condition?

☐ Medications ☐ Chiropractic Care
☐ Physical Therapy ☐ Injections
☐ Home Exercises ☐ Other: _________

If so, please describe: ________________________
Have you had any special tests:

☐ X-ray ☐ EMG
☐ MRI ☐ CT scan
☐ Blood Test ☐ Other: _________

What were the results: ________________________
____

List any medications you are taking? _____________
____

List any allergies you have? ___________________
____

List any vitamins/herbs/minerals that you take?
____

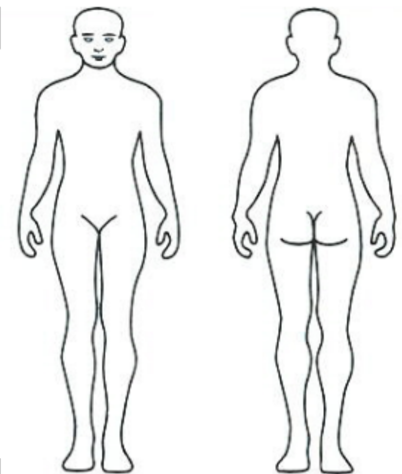
EXERCISE	WORK ACTIVITY	HABITS
☐ None	☐ Sitting	☐ Smoking
☐ Moderate	☐ Standing	☐ Alcohol
☐ Daily	☐ Light Labor	☐ Coffee/Caff. drinks
☐ Heavy	☐ Heavy Labor	☐ High Stress Level

3 HEALTH HISTORY

Please circle yes or no to indicate if you have had any of the following:

yes	no	High Blood Pressure	yes	no	Osteoarthritis
yes	no	Cardiac. conditions (pacemakers)	yes	no	Weight Loss or Gain
yes	no	Respiratory conditions	yes	no	Bowel/Bladder issues
yes	no	Allergies or Asthma	yes	no	Stroke
yes	no	Neurological disorders	yes	no	Diabetes
yes	no	Cancer, Malignances,Tumors	yes	no	Bleeding Disorders
yes	no	Rheumatoid Arthritis	yes	no	Migraine Headaches
yes	no	AIDS/HIV	yes	no	Hepatitis

Are you pregnant? yes no Due date: ___________________



Mark an X on the picture where you continue to have pain, numbness, or tingling.

4 PAIN SCALE

Rate the severity of your pain on a scale from 1 (least) to 10 (severe pain) __________
How often do you have this pain? _______ Is it constant or does it come and go?______
Type of pain: ☐ sharp ☐ dull ☐ throbbing ☐ numbness ☐ aching ☐ shooting
☐ burning ☐ tingling ☐ cramps ☐ stiffness ☐ swelling ☐ other ____________________
Activities or movements that are painful to perform ____