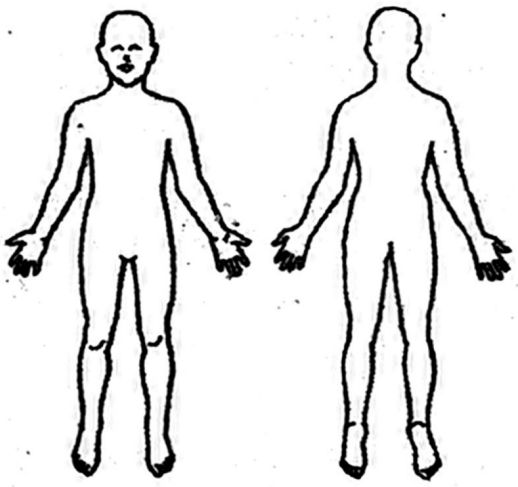
# Physical Therapy Patient History

Name:_____Date of Birth:_____AB Health #_____
Address:_____
Home Phone:_____ Cell:_____ Work:_____
Occupation: _____

Are you currently off work because of this problem? O Yes O No O Light duty
When did your problems begin?
How did your problems begin?

**Rate your pain:** No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

**Draw your pain:**



**Describe your pain**: **O** Dull **O** Ache

**O** Sharp **O** Stabbing **O** Pins & Needles

**O** Shooting Pain **O** Burning **O** Throbbing

**O** Twinge **O** Numbness/Tingling

**O** Other

**Is your pain constant**? **O** Yes **O** No

**Intermittent**? **O** Yes **O** No

**Fluctuates with activity? O** Yes **O** No

**Wakes you up at night? O** Yes **O** No

**What makes your symptoms worse**?

**O** Siting **O** Standing **O** Walking **O** Lifting **O** Bending **O** Lying down **O** Squatting **O** Stress O Other

**Are you ever totally pain free? O** Yes **O** No

**What makes your symptoms better? O** Sitting **O** Standing **O** Walking **O** Lifting **O** Bending
**O** Lying down **O** Other

**What time of day are your symptoms worst? Best?**

**Do you feel you are: O** Getting better **O** Getting worse **O** Staying the same

**Have you had this problem before? O** Yes **O** No

Any previous treatment for your current condition? ☐ Yes ☐ No

Have you had diagnostic studies for your current condition? (X-ray, MRI, CT scan...)
☐ Yes ☐ No

Any other orthopedic problems? ☐ Yes ☐ No
If yes, please explain:_____
_____

Any medical problems? ☐ Yes ☐ No
If yes, please explain:_____
_____

Any surgeries? ☐ Yes ☐ No
If yes, please explain:_____
_____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition:_____
_____
_____
_____

Have you ever had a history of any of the following? ☐ Major injury to head/spine ☐ Cancer/tumors ☐ Osteoporosis ☐ Dizziness/blackouts ☐ Heart problems/angina ☐ Diabetes ☐ Pacemaker ☐ Sudden weight loss/gain ☐ Severe pain at night ☐ Smoking ☐ Bruising easily ☐ Asthma ☐ Frequent falls ☐ Loss of bowel/bladder control ☐ Numbness ☐ Seizures/epilepsy ☐ High blood pressure ☐ Coordination loss

Does your current condition limit you in carrying out job duties? ☐ Yes ☐ No
Household duties? ☐ Yes ☐ No

What are your goals in physical therapy?_____
_____
_____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.