PATIENT HISTORY FORM

NAME:_____ DATE:_____

HEIGHT:_____ WEIGHT:_____ DATE OF BIRTH: _____

PHYSICIAN: _____

PRESENT INJURY

Pleas specify the body region(s) involved for which you are seeking physical therapy services today. (i.e. left knee)

_____

Date of Injury or Estimated Date of Onset: _____

Please circle all previous treatment that you have received for this condition

Medicine Injections Surgery Chiropractic Physical Therapy Other:_____

On a scale from 0 (least) to 10 (worst) which best describes your current level of pain. Circle the number that most correctly corresponds with your pain.

_____

0 1 2 3 4 5 6 7 8 9 10

Do you smoke? NO YES

Please circle all medications that you are currently taking:

Pain Anti-inflammatory Blood Thinner Blood Pressure Meds

List pertinent past surgeries:_____

_____

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

_____

Continued onto the back→

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

Recent Weight Changes	No	Yes
Night Sweats, pain, fevers	No	Yes
Chest Pain/heart trouble	No	Yes
High/Low Blood Pressure	No	Yes
Pacemaker	No	Yes
Chronic Obstructive Pulmonary Disease (COPD)	No	Yes
Asthma	No	Yes
Muscle Pain/Cramps	No	Yes
Muscle Weakness	No	Yes
Stiffness/Swelling in Joints	No	Yes
Rheumatoid Arthritis/ joint pain	No	Yes
Fibromyalgia	No	Yes
Diabetes	No	Yes
Nausea/Vomiting	No	Yes
Abdominal Pain	No	Yes
Convulsion/Seizures	No	Yes
Numbness/Tingling	No	Yes
Head/Spinal Injury or Surgery	No	Yes
Dizziness	No	Yes
Confusion/Memory Loss	No	Yes
Cancer	No	Yes
HIV/AIDS	No	Yes
Hepatitis	No	Yes
Females: Could you be pregnant?	No	Yes