THRIVE PHYSICAL THERAPY

Date: _________ Name: _____________________________

DOB: ________________ Acct: _____________________

Insurance: ____

Patient Health History and Information

Age: _____ **Height:** ________ **Weight:**______ **Sex:** M F **Dominant hand:** R L **Could you be or are you pregnant:** Yes No

Occupation/job title: ________________________________ Self Student Full time Part time Retired Unemployed

Reason for Therapy:____

Date of injury or onset of symptoms: ___/___/___

Please describe how your injury/problem occurred:____

Please list any treatment you have received for this condition (ie. PT, chiro)________________________________

Injection: type: ______________ ___/___/___ Surgery: type:______________ ___/___/___ Other:_____________ ___/___/___

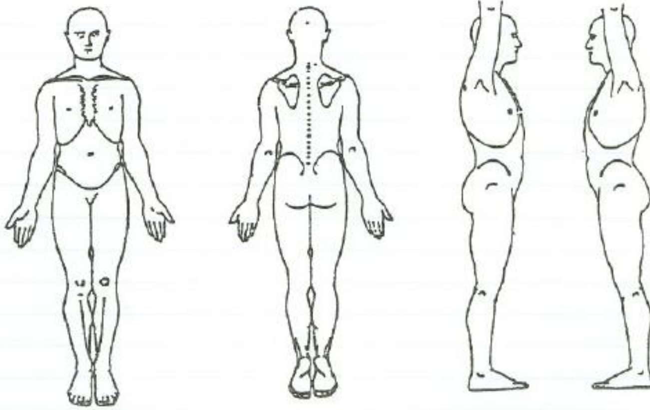
For this condition have you had any of the following? EMG___/___/___ X-ray ___/___/___ MRI / CT scan ___/___/___

Have you had this problem before? _______ When?____________ What kind of treatment?___________________________

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain **//**= Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing	Increasing	Staying the same			
Weakness	Giving way	Throbbing	Other:________________		

Which side are we seeing you for?: Right Left

What makes your symptoms worse? ____

What makes your symptoms better? ____

Limitations due to your current problem:____

____Laying down	____Bending	____Turning Head	____Sleep/Awake from Pain
____Sit to stand	____Work	____Sitting	____Self Care/Hygiene
____Up/Down Stairs	____Driving	____Walking	____Home activities
____Squatting/Lifting	____Swallowing	____Standing	____Repetitive activities
____Looking overhead	____Talk/Chew/Yawn/All	____Reaching	____Sport/Recreation
____Taking a breath	____ Cough/sneeze pain	____Child care	

What are your goals for therapy? (Two things you want to be able to do again or do better)

1.____ **2.** ____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other:________________________	Yes	No
Headaches	Yes	No			

Date:________ Name:_______________________________
D.O.B._________ Patient Account _________________
Insurance: ____

Who referred you to Physical Therapy? _______________________________**Primary Physician**: _______________________________

How did you hear about Thrive Physical Therapy? Physician Friend/relative Website/Google Previous patient Self Coach Other

<u>GENERAL HEALTH HISTORY</u>:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor

Living Situation: Alone Spouse Family Others

Do you exercise? Yes No _____x/week Type:____

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:_____________

Employer:___________________________ **Current work duty:** Full duty Restricted duty **Work days missed:** ______

QRC and/or Adjuster (if you have one)**:**____

Surgical history: ____

Have you or anyone in your immediate (brother, sister, child, parent, grandparent) **family ever been diagnosed with any of the followin**

Condition				Condition			
Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Anxiety	Self	Family	No	Thyroid problems	Self	Family	No
Cancer	Self	Family	No	Epilepsy/dizziness	Self	Family	No
High Cholesterol	Self	Family	No	Tuberculosis	Self	Family	No
High blood pressure	Self	Family	No	Anemia/blood disorder	Self	Family	No
Heart trouble/angina	Self	Family	No	Multiple Sclerosis	Self	Family	No
Diabetes	Self	Family	No	Circular/vascular problems	Self	Family	No
Stroke	Self	Family	No	Chemical dependency	Self	Family	No
Osteoporosis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Osteoarthritis	Self	Family	No	AIDS/HIV	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Hepatitis	Self	Family	No
Depression	Self	Family	No	Bladder/bowel problems	Self	Family	No
Headaches	Self	Family	No	Other:			

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical/occupational therapy treatment: No _____ Yes _____

Patient Signature: _______________________________________ **Date** ____/____/____

Reviewed by Therapist: ____________________________________ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:____ **Date** ____/____/____

Reviewed by Therapist: ____________________________________ **Date** ____/____/____