Patient History and Conditions

Answering the following questions will assist the therapist in providing a safe and effective treatment program:

Patient's Name: _____ Today's Date: _____

Age: _____ Height:_____ Weight: _____

What problem(s) bring you here today? _____

When did the symptom(s) begin? _____

Have you had any therapies for this problem before? ☐ Yes ☐ No

If yes, where? _____ When?_____

Have you had any surgeries associated with this problem? ☐ Yes ☐ No

If yes, when? _____ Type of Surgery? _____

Have you had any X-rays, MRIs, nerve testing done recently? ☐ Yes ☐ No

If yes, when? _____ Results? _____

List all medications or supplements you are taking:

_____

_____

_____

Do you have allergies or reactions to drugs/medications? ☐ Yes ☐ No

If yes, what? _____

Please mark appropriate answer if you have had or currently have any of the following:

High Blood Pressure	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
If yes, under control?	☐ Yes	☐ No	If yes, Type:	☐ One	☐ Two
Heart Attack	☐ Yes	☐ No	Seizures	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Shortness of Breath	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Balance Problems	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Nervous Disorders	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Vision Problems	☐ Yes	☐ No	Metal Implants	☐ Yes	☐ No
Hearing Problems	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No	Others (please describe)		
If yes,	☐ hyper	☐ hypo	_____		

General Health:

1. Have you had any illnesses recently? _____
2. Have you had any unexplained weight gain or loss? _____

3. Do you have any sores that have not healed? _____
4. Do you smoke? _____ if so, how many packs/day:_____
5. Has your Doctor placed any restriction with respect to cardiovascular or resistive exercise? ☐ Yes ☐ No
   If yes, please explain:_____

Work Environment: Does your job involve the following, please mark appropriate box?

☐ Prolonged sitting ☐ Prolonged standing ☐ Prolonged walking

☐ Lifting, bending, twisting, climbing

☐ Use of equipment; if yes, explain _____

History of Falls: please mark appropriate box

☐ I have had no falls ☐ I have just started to lose my balance

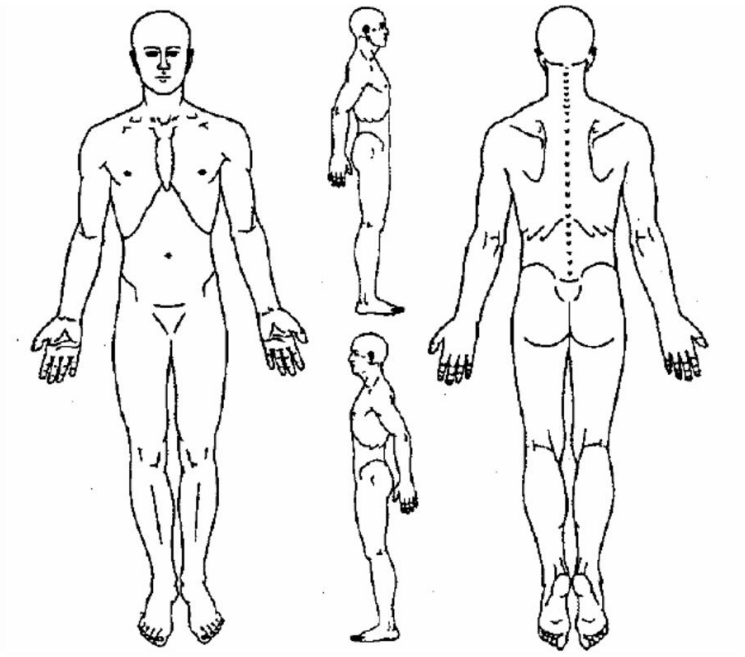
☐ I fall occasionally ☐ Certain factors make me cautious (i.e. Curbs, ice, stairs)

Pain Questionnaire: On a scale from 0 to 10 (0 being no pain, 10 being excruciating pain)

What is your pain at best?	0 1 2 3 4 5 6 7 8 9 10
What is your pain at worst?	0 1 2 3 4 5 6 7 8 9 10
What is your pain right now?	0 1 2 3 4 5 6 7 8 9 10

Indicate by circling areas of the body diagram where you feel symptoms. Use the key to indicate different types of symptoms:

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗
- - - - - -	o o o o o	^ ^ ^ ^	x x x x	⊗ ⊗ ⊗ ⊗



The above information is correct to the best of my knowledge:

Patient's Signature: _____ Date:_____

Therapist's Initials: _____ Date:_____