

Physical Therapy Medical History

A complete medical history is necessary for a thorough evaluation. **Please thoroughly answer the following questions.**

Name: _____ Date of Birth: _____ Age: _____ Today's Date: _____
 Date of Onset/Injury: _____ Scheduled follow up visit with Physician: _____
 Rehab Nurse: Y N Name: _____ Lawyer Y N Name _____
 How did your pain/injury occur? _____

When did you first notice the pain/injury or have functional problems due to this condition? _____

Dates of Subsequent Episodes: _____ Date of most recent episode: _____

Is your pain: **Getting Better** **Getting Worse** **Staying the Same**
 Is your pain: **Constant** **Can be Pain Free at Times**

Please rate your **pain intensity** according to a 0-10 Pain Scale (0 =none; 5 =moderate; 10 =Extreme agony):

Best: _____ Worst: _____ Average: _____ Now: _____

Please rate how you perceive that your pain limits your daily routine (0= no limits, 10 = completely limited)

Best: _____ Worst: _____ Average: _____ Now: _____

Shade in your pain areas on the Body Chart and describe your pain and describe you pain below.

Stabbing Burning Pins/Needles Throbbing Numbness
 Aching Soreness Sharp Dull
 Other: _____

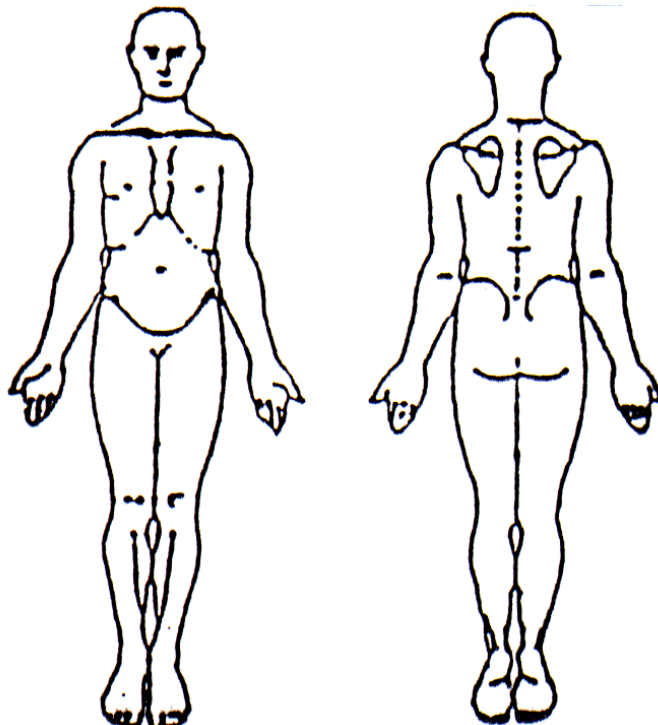
What makes your symptoms worse: Bending Sitting Standing
 Walking Prolonged activity Exercise Nothing Specific
 Other: _____

What makes your symptoms better: Medications Rest Heat
 Lying down Exercise Massage Activity Nothing
 Other: _____

When is your pain the worst: AM As day Progresses PM

Have you had any of the following for this injury/ condition:

Type of surgery: _____
 When? _____
 Type of Injection: _____
 When? _____ Did it Help? Y N
 Diagnostic Tests: X-ray: _____ CT Scan _____
 EMG/NCV _____ MRI _____ Bone Scan _____
 Other: _____
 Please list **Current Medication:** _____



For your current injury/condition **have you seen or received** any of the following:

- Medical Doctor From _____ to _____
- Osteopathy From _____ to _____
- Podiatrist From _____ to _____
- Psychiatrist From _____ to _____
- TENS unit From _____ to _____
- Muscle Stimulation Unit From _____ to _____
- Physical Therapist From _____ to _____
- Chiropractor From _____ to _____
- Dentist/Orthodontist From _____ to _____
- Psychologist From _____ to _____
- Home Traction Unit From _____ to _____

Please look at the list below and circle the number that indicates how your injury/condition has affected your daily life.		Have you been diagnosed or have any of the following conditions? Place an X next to any condition that you have.	
1=No problem		<input type="checkbox"/>	Heart Disease
2=Can do with some difficulty		<input type="checkbox"/>	Heart Attack: When: _____ Pace Maker Y N
3=Can do with great difficulty		<input type="checkbox"/>	High Blood Pressure
4=Cannot do all		<input type="checkbox"/>	Stroke
		<input type="checkbox"/>	Seizures
Sitting	1 2 3 4	<input type="checkbox"/>	Fainting Spells, Balance Problems
Standing	1 2 3 4	<input type="checkbox"/>	Nervous Disorders
Squatting	1 2 3 4	<input type="checkbox"/>	Cancer: Location: _____ When: _____
Going up or down stairs	1 2 3 4	<input type="checkbox"/>	Diabetes: Controlled: Y N Uncontrolled Y N
Walking	1 2 3 4	<input type="checkbox"/>	Asthma
Position Change (sitting to stand, etc)	1 2 3 4	<input type="checkbox"/>	Other Lung Disease
Sports/Recreation (running/golf, etc)	1 2 3 4	<input type="checkbox"/>	Arthritis
Driving/riding in a vehicle	1 2 3 4	<input type="checkbox"/>	Osteoporosis
Lying Down	1 2 3 4	<input type="checkbox"/>	Pregnant: Y N Due Date: _____
Sleeping at night	1 2 3 4	<input type="checkbox"/>	Menstrual Problems: _____
Stomach Back Side R L Surface: Firm soft sag W. bed		<input type="checkbox"/>	Incontinence (bladder/bowel)
Lifting/Carrying (greater than ___ lbs)	1 2 3 4	<input type="checkbox"/>	HIV/AIDS
Getting Dressed	1 2 3 4	<input type="checkbox"/>	Hepatitis
Daily Job Activities	1 2 3 4	<input type="checkbox"/>	Prosthesis: Joints: _____ Limbs _____
Housework/yard work	1 2 3 4	<input type="checkbox"/>	Dentures: Full Partial Metal Plastic
Reaching (overhead/behind back, etc)	1 2 3 4	<input type="checkbox"/>	Fractures: Location: _____ Date: _____
Gripping	1 2 3 4	<input type="checkbox"/>	_____
Flexing/extending arm/elbow	1 2 3 4	<input type="checkbox"/>	Pins/screws: Y N Where: _____
Movement of mouth/jaw	1 2 3 4	<input type="checkbox"/>	_____
Swallowing	1 2 3 4	<input type="checkbox"/>	Surgeries last 5 years? _____
Eating	1 2 3 4	<input type="checkbox"/>	_____
Hygiene (Brushing hair/teeth, etc)	1 2 3 4	<input type="checkbox"/>	Prior injuries: _____
Current Exercise Program or Leisure Activities: _____ _____		<input type="checkbox"/>	Other: _____
Other: _____ _____ _____		<input type="checkbox"/>	_____

SOCIAL:

Marital Status: M S D W Children: Yes No Number _____ Ages _____
 Do you smoke: Y N (_____ packs/day) Alcohol consumption: Y N (socially occasionally rarely _____)
 Do you drink coffee Y N (____ cups/day) Caffeinated sodas Y N (____ drinks/day) Chocolate Y N Quantity: _____

Occupation: _____ Employer: _____
 Length of time at this job: _____ Describe what you do: _____

How has your injury limited your ability to work? _____

