Patient Medical History & Status

Name:________________________________M/F Date of Birth: ____/____/_____ Age:______

Email:____

Is this injury related to an Auto Accident? **Yes** **No**

Did this injury happen while at work? **Yes** **No**

Do you have a current Workers Compensation Claim Open? **Yes** **No**

I am living: Alone | Alone but with assistance for my needs | With an adult person(s) | With children in home ages, ___________

I am currently: Employed; my job is ____

I am on sick leave | I am on disability | Applying for disability

I am unemployed | I am retired | I work inside the home

My physical activities include:

Reading, watching TV

Walking, gardening, housework, occasional physical exercise

Regular physical exercise at least twice per week

I began having pain/symptoms on or about : _____/_____/______

I have had this condition: Never until now | Once | Many times before

What activities and/or activities make your pain worse? (circle below)

Sitting   Standing   Walking   Bending   Stairs   Transfers   Squatting   Kneeling   Lying down

Driving   Reaching overhead   Reaching behind back   Lifting objects   Dressing   Cooking   Cleaning

Gripping objects

Other: ____

What eases your pain? (circle below)

Ice Heat Rest Stretching Therapy Medication Lying down Standing Sitting Bending

Other: ____

Have you had or scheduled for diagnostic imaging (i.e. X-ray, MRI, Nerve Conduction study, etc.)?

*Explain:*____

Are you able to perform any activities that you were not able to before starting Physical Therapy/ Occupational Therapy?

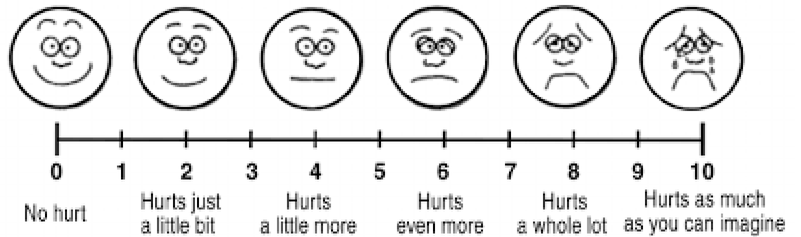
Yes **No**

*Explain:*____

Have you ever had Physical Therapy / Occupational Therapy before? Yes No

____

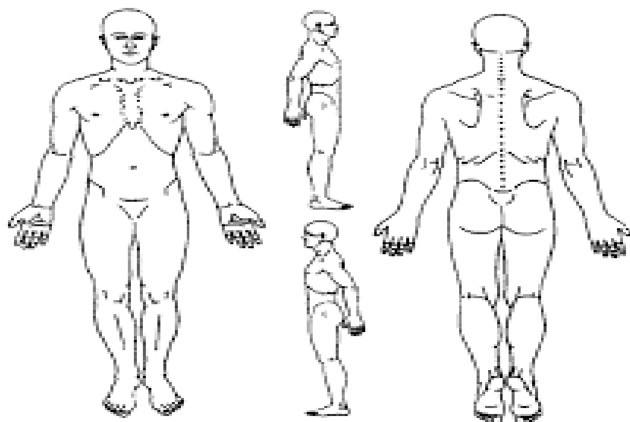
Please rate you pain level using the tool



At worst: _____/10
Current: _____/10
Best: _____/10

Please mark the area of pain or discomfort on the chart provided, using this appropriate symbols:

Burning: ^ ^ ^ ^ ^
Sharp: + + + + +
Dull/Achy: X X X X X
Throbbing: o o o o o
Shooting: →→→→→



Numbness/Tingling : = = = = = =

My Pain is: Constant Intermittent

Are you currently taking **any** medication(s) ? Yes No

List current medication(s). Please include Dose/Frequency (or provide list):

____

____

____

____

Currently I am experiencing the following *(Check all that apply):*

	Unexplained weight loss		Headaches		Changes in Bowel/Bladder function
	Increased appetite at night		Nausea / Vomiting		Depression
	Fever / Chills / Sweats		Numbness / Tingling		Shortness of breath
	Changes in appetite		Muscular Dystrophy		**Other:**______________________
	Difficulty swallowing		Dizziness		

Have you fallen over the past 12 months? Yes No **If yes, how many times?** __________

Have you **ever** had surgery? Yes No

Date of surgery: _____/_____/______

Type of surgery: ____

Past Medical History: Do you now have/or have you ever had any of the following conditions? ***(check all that apply)***

	Alzheimers		History of Cancer
	Cardiovascular Disease		Huntington's
	Cauda Equina Syndrome		Immunosuppression
	Stroke		Lupus

	Current infection		Muscular Dystrophy
	Diabetes type 1		Obesity
	Diabetes type 2 (adult onset)		Osteoarthritis
	Fibromyalgia		Parkinson's
	Fracture or suspected fracture		Rheumatoid Arthritis
	High Blood Pressure		Traumatic Brain Injury
	Pace Maker		Other:___________________________

What activities are you having difficulty doing because of your pain or dysfunction?

____

What is your personal goal for Physical Therapy / Occupational Therapy?

____

Is there any other information or concerns you would like to share with your therapist?

____

Patient Name (printed): ____ Date _____/_____/______

Patient/Guardian signature:_____________________________________

To our patients: Although many of these questions may not seem relevant to your visit today. We ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal injuries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for you overall wellbeing and health.

For Therapist use:

Self-reported or functional index score: _________/_________

Oswestry Cervical Index DASH LEFS DHI FOTO PRWE UEFS Other:_________

____

Therapist signature Date