



PATIENT HISTORY

NAME: _____ SSN: _____
 TODAY'S DATE: _____ ADDRESS: _____
 CHART #: _____ CITY: _____
 REFERRING PHYSICIAN: _____ STATE/ZIP: _____
 DR'S PHONE: _____ HOME PHONE: _____
 DR'S FAX: _____ WORK PHONE: _____
 NEXT MD APPOINTMENT DATE: _____ EMPLOYER NAME: _____
 DATE OF BIRTH: _____ CELL PHONE: _____

INSURANCE INFORMATION: **Please bring ALL of your current insurance cards to your appointment so that we can copy each one for your file.**

CHIEF COMPLAINT: _____ DATE OF INJURY/ONSET: _____
 HISTORY OF INJURY/ONSET: _____

• HAVE YOU EVER HAD ANY XRAYS, MRI, CT SCANS, ETC., RELATING TO THIS CONDITION:
 YES___ NO___ RESULT, IF KNOWN: _____

• HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS: (PLEASE CHECK ALL THAT APPLY)
 ___ ALLERGIES (SPECIFICALLY TAPE, CREAMS/LOTIONS, ETC.)
 ALLERGIC TO: _____

- | | |
|-----------------------------|----------------------------------|
| ___ OSTEOARTHRITIS | ___ HEPATITIS |
| ___ RHEUMATOID ARTHRITIS | ___ HIGH BLOOD PRESSURE |
| ___ ASTHMA | ___ HIV/AIDS |
| ___ BLOOD CLOT | ___ KIDNEY DISEASE |
| ___ CANCER | ___ LUNG PROBLEMS |
| WHAT TYPE? _____ | ___ NURSING/BREASTFEEDING |
| ___ DEPRESSION/ANXIETY | ___ STROKE/TIA'S |
| ___ DIABETES | ___ THYROID PROBLEMS |
| ___ DRUG/ALCOHOL DEPENDENCY | ___ OSTEOPOROSIS |
| ___ EPILEPSY/SEIZURES | ___ PREGNANCY |
| ___ FIBROMYALGIA | ___ PSORIASIS |
| ___ GASTRIC REFLUX | ___ PREVIOUS CORTISONE INJECTION |
| ___ GLAUCOMA | DATE OF LAST INJECTION? _____ |
| ___ HEART ATTACK | ___ PREVIOUS FRACTURES |
| ___ HEART FAILURE | ___ PREVIOUS ORAL STEROID |



PATIENT HISTORY

- PACEMAKER
- DEFIBRILLATOR
- REQUIRE USE OF NITROGLYCERIN
- OTHER HEART PROBLEMS
- OTHER PSYCHIATRIC PROBLEMS
- UNEXPLAINED WEIGHT LOSS
- LUPUS

PLEASE LIST ALL SURGERIES: _____

PLEASE LIST ALL CURRENT MEDICATIONS INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER HERBALS/SUPPLEMENTS (PLEASE INCLUDE DOSAGES FOR ALL MEDICATIONS): _____

HAVE YOU HAD ANY FALLS WITHIN THE PAST YEAR? IF SO, HOW MANY? INJURIES RESULTING FROM FALL(S)?

OCCUPATION/PRIMARY JOB DEMANDS (i.e., PROLONGED SITTING/STANDING, COMPUTER WORK, LIFTING, PUSHING, PULLING, UNEVEN SURFACES, ETC.) _____

JOB STATUS (CIRCLE ONE):

- WORKING FULL TIME, REGULAR DUTY
- WORKING FULL TIME, LIGHT DUTY
- WORKING RESTRICTED HOURS, REGULAR DUTY
- WORKING RESTRICTED HOURS, LIGHT DUTY
- OUT OF WORK SECONDARY TO INJURY
- UNEMPLOYED
- RETIRED

RECREATIONAL ACTIVITIES: _____

ANYTHING SPECIFIC THAT AGGRAVATES PAIN/PROBLEM: (i.e. SPECIFIC ACTIVITY, USE OF HEAT, ETC. _____

ANYTHING SPECIFIC THAT RELIEVES YOUR PAIN/PROBLEM: _____



PATIENT HISTORY

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES OF ANY TYPE (I.E. NURSING, AIDES, WOUND CARE, I.V., PHYSICAL THERAPY, ETC.)? YES ___ NO ___ UNSURE (PLEASE EXPLAIN) _____

LIST PRIOR TREATMENTS THAT YOU HAVE HAD FOR THIS CONDITION (I.E. PHYSICAL OR OCCUPATIONAL THERAPY, INJECTIONS, CHIROPRACTIC TREATMENT, ETC.): _____

MY PERSONAL GOAL (S) FROM PHYSICAL THERAPY TREATMENT ARE: _____

RATE YOUR PAIN ON A SCALE FROM 0 – 10 (0 = NO PAIN AT ALL; 10 = WORST PAIN IMAGINABLE) DURING THE FOLLOWING SCENARIOS:

- MY PAIN AT THIS MOMENT IS _____ .
- MY PAIN IS _____ MOST OF THE TIME DURING A NORMAL DAY.
- MY PAIN IS _____ AT WORST.
- MY PAIN IS _____ AT BEST.

IN CASE OF AN EMERGENCY, WHOM SHOULD WE CONTACT?

NAME _____

RELATIONSHIP _____

HOME PHONE _____

WORK PHONE _____

CELL _____