Patient's History of Current Injury/Illness

Name: _____ **Today's Date**: _____

Age: _____ **Date of Birth**: _____ **Sex**: _____ **Marital Status** _____ **# Children** _____ **Ages**_____

Occupation: _____ **R- handed** ____ **L-handed**____ **Ht**._____ **Wt**. _____

Have you ever been a patient here before? Yes_____ No _____; If yes, for the ____same or ____different problem?

Please indicate for which body region you are seeking treatment:

__Neck __Mid Back __Low Back __Shoulder __Elbow __Hand/wrist __Hip __Knee __ Ankle/foot __ Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes_____ No _____

If yes, specify: _____

_____

Have you ever had similar symptoms in the past? Yes ____ No ____ If **yes**, when? _____

_____

Have you recently had the following tests? Yes ____ No____ If **yes**, check all that apply:

____x-rays	____Bone Scan	____Myelogram ____	____ EKG
____CT Scan	____EMG	____Stress Test	____Echocardiogram
____MRI	____Blood Tests	____Pulmonary Function Test	____Other (Please list)_____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

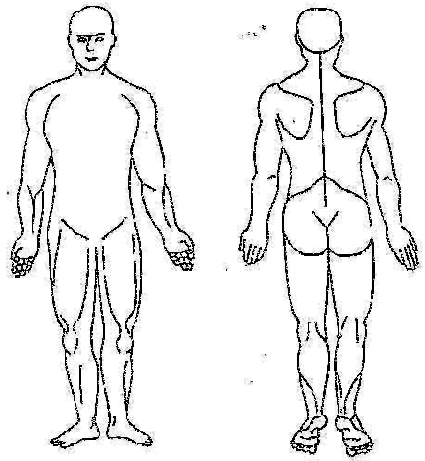
Pain free *Unconscious Pain*

Describe the character of your pain? (What does it feel like…sharp, dull, achy, etc.?)

_____

_____

_____



Is the pain there all the time (constant)? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

_____

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

Please use the body diagram above and *Shade Areas of Pain*

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes ___ No ____ Describe _____

What activities/positions make your pain worse?_____

_____

_____

What activities/positions make your pain better? _____

_____

_____

Have you <u>previously</u> seen any other health care provider for this problem? ____ Yes ____No

___Physician ___Osteopath ___Podiatrist ___Other (Please list below)

___Physical Therapist ___Chiropractor ___Dentist _____

Are you currently seeing any other health care provider for this condition? ____Yes ____No; If Yes, please list:

_____

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ____ If yes, please describe: _____

Please <u>circle</u> those treatments listed below that have been tried in the past:

___Physical Therapy ___Chiropractic ___Acupuncture ___Braces ___Collars ___Tens Unit ___Injections

___Medications ___None ___Other (please describe):_____

Optimal Instrument Difficulty-Baseline

Scale (1-5) Please circle the numbers below which you think are appropriate

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Non-Applicable (N/A)**
1. Lying flat	1	2	3	4	5	
2. Rolling over	1	2	3	4	5	
3. Moving-lying to sitting	1	2	3	4	5	
4. Sitting	1	2	3	4	5	
5. Squatting	1	2	3	4	5	
6. Bending/stooping	1	2	3	4	5	
7. Balancing	1	2	3	4	5	
8. Kneeling	1	2	3	4	5	
9. Walking-short distance	1	2	3	4	5	
10. Walking-long distance	1	2	3	4	5	
11. Walking-outdoors	1	2	3	4	5	
12. Climbing stairs	1	2	3	4	5	
13. Hopping	1	2	3	4	5	
14. Jumping	1	2	3	4	5	
15. Running	1	2	3	4	5	
16. Pushing	1	2	3	4	5	
17. Pulling	1	2	3	4	5	
18. Reaching	1	2	3	4	5	
19. Grasping	1	2	3	4	5	
20. Lifting	1	2	3	4	5	
21. Carrying	1	2	**3**	**4**	**5**	

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Medication	Dosage	Reason for Taking

Use additional sheet if more space is needed

Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

__ Private Home __Private Apartment __Rented Room __Group Home __Assisted Living __Skilled Facility __Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

__Live Alone __Spouse/Significant Other __Child/Children __Other Relative __ Personal Care Attendant __Other

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): _____

_____

What are your goals for your course of physical therapy? _____

_____

_____

__

At the present time, would you say your health is excellent, very good, fair, or poor? _____

_____ _____

Patient Signature Date

_____ _____

Evaluating Physical Therapist Signature Date

Medical History

Do you have or did you have any of the following: Please check Yes or No

Condition	Yes	No	Indicate Date of Injury/Onset
Diabetes			
Heart Disease			
Heart Attack			
Stroke			
High Blood Pressure			
Heart Surgery			
Pacemaker			
Headaches			
Lung Problems			
Kidney Problems			
Nervous Disorders			
Seizures			
Pregnancy			
Sensitivity to Heat			
Sensitivity to Cold			
Fractures			
Other Surgeries			
Allergies			
Other (Specify)			
Smoking			

Reviewed by:_____Date:_____

Reviewed by:_____Date:_____