PURPOSE
PHYSICAL THERAPY
CARE WHERE YOU ARE

Physical Therapy Patient History

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you

NAME:_____ Today's Date_____

Primary problem we are seeing you for_____
When did this start?_____

Occupation: _____
Currently working: Yes No Full time: Yes No Modified duty: Yes No

Please indicate your typical level of activity: Sedentary Active Athletic

Do you exercise beyond normal daily activities and chores: Yes No

Please rate your health: Excellent Good Fair Poor Do you smoke: Yes No

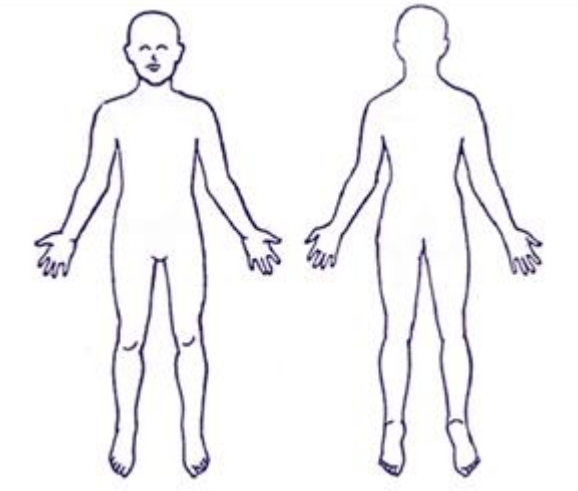
Medical/surgical history
Please check if you have ever had the following:
□ Allergies Latex: Yes / No □ Multiple sclerosis □ Depression/Anxiety
□ Arthritis OA RA □ Cancer □ Broken bones/fractures □ Infectious disease
□ Repeat Infections □ Polio □ Osteoporosis □ Parkinson's □ Kidney problems
□ Blood disorders □ Seizures/epilepsy □ Stroke
□ Circulation/vascular problems □ Development or growth problems
□ Heart problems Pacemaker □ Thyroid problems □ Skin diseases
□ High blood pressure □ Diabetes/high blood sugar □ Low blood sugar
□ Lung problems □ Ulcers/stomach problems □ Head injury
□ Unusual reaction to heat/cold □ Other:_____
□RecentSurgeries:_____

Recent changes/Currently Experiencing:
(Check all that apply)
□ Chest pain □ Pregnant, or think you might be □ Heart palpitations □ Difficulty sleeping □ Fever/chills/sweats □ Cough □ Nausea/vomiting □ Headaches
□ Hearing problems □ Shortness of breath □ Vision problems
□ Dizziness or blackouts □ Weight loss/gain-changes in appetite □ Pain at night
□ Coordination problems □ Loss of balance □ Falling: Date of recent fall_____
□ Weakness in arms or legs □ Difficulty walking □ Joint pain or swelling
□ Other:_____

Current Medications: (or provide a list):_____

(Continue to next page)

If you have pain, please list the number that best represents your pain below
Current pain: 0 1 2 3 4 5 6 7 8 9 10
Worse pain: 0 1 2 3 4 5 6 7 8 9 10
Best Pain: 0 1 2 3 4 5 6 7 8 9 10



Draw your pain:
Describe your pain: _____
Is your pain constant? ☐ Yes ☐ No
Intermittent? ☐ Yes ☐ No
Fluctuates with activity? ☐ Yes ☐ No
Wakes you up at night? ☐ Yes ☐ No

What makes your symptoms worse?
☐ Sitting ☐ Standing ☐ Walking☐Lifting ☐ Bending ☐ Lying down
☐ Other_____

What makes your symptoms better? ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting
☐ Bending ☐ Lying down ☐ Other_____

WOUND HISTORY:
When did the wound start?_____
How have you been treating the wound?_____
What has made it better?_____Worse?_____

What are your goals for physical therapy?_____
_____

Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.