CREATIVE PATHWAYS PHYSICAL THERAPY
Patient History Form

MEDICAL HISTORY: A complete medical history is necessary for a thorough evaluation. Please answer the following questions.

Your Name: **Today's Date:**

Date of Birth: **Age:** **Height:** **Weight:**

Sex: **If female,** are you currently pregnant? ☐ No ☐ Yes, **If yes,** ☐1st ☐2nd ☐3rd Trimester?

Do You Smoke? ☐ No ☐ Yes

Have you ever been diagnosed with any of the following?

Tuberculosis	☐ No	☐ Yes	Cancer	☐ No	☐ Yes	Arthritis	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes	Hepatitis	☐ No	☐ Yes	Stroke	☐ No	☐ Yes
Heart Condition	☐ No	☐ Yes	Epilepsy	☐ No	☐ Yes	Respiratory Problems	☐ No	☐ Yes

Other: _____

Who referred you to physical therapy? _____

Primary Physician _____

Tell Us About Your Condition

When did you first notice the pain or have functional problems due to the condition/injury (Please provide approximate dates): _____

Recent flare-up? ☐ No ☐ Yes If yes, when _____

What activities are limited by this condition? (e.g. lift, reach): _____

How did your injury/symptoms occur? _____

What are your goals for physical therapy? _____

Are your symptoms: ☐ Constant? ☐ Intermittent? ☐ Getting Better?
☐ Getting worse? ☐ Staying the same?

What makes your symptoms better? _____

0-10 pain scale (0 = No Pain; 5= Moderate Pain; 10 = The Most Extreme Pain)

Worst pain rating: 0 1 2 3 4 5 6 7 8 9 10

Best pain rating: 0 1 2 3 4 5 6 7 8 9 10

For this injury, has your medical care included: (check those that apply)

☐ Surgery: When? ___/___/___ What kind?_____

☐ Injection: When? ___/___/___ Did it help? ☐ Yes ☐ No

☐ Other treatment:

☐ Physical therapy If yes, when? ___/___/___to ___/___/__
What was done?_____

☐ Chiropractor If yes, when? ___/___/___to ___/___/___
What was done? _____

☐ Medications: _____

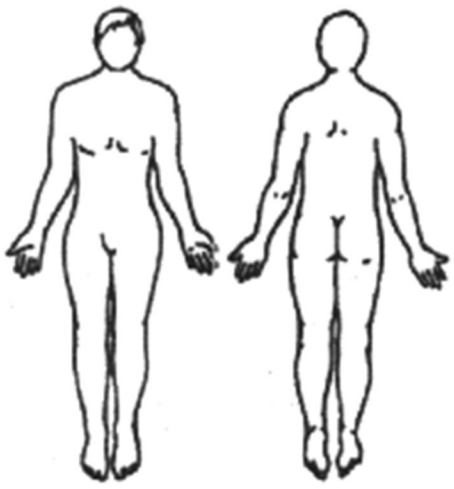
☐ X-ray _____ ☐ MRI _____

☐ CT scan _____ ☐ Other: _____

☐ Exercises: What kind? _____

Indicate on body diagrams **where** your symptoms are located

■ = Pain ***III*** = Numbness



Additional Comments: _____

Work Information

Who is your employer? _____

What is your job title/responsibilities? _____

Are you currently working? ☐ No ☐ Yes If yes, number of hours per week_____

Does your injury/condition interfere with your work? ☐ No ☐ Yes

How many total work days have you missed? _____

Please indicate either "Yes" or "No" as to whether each of the following is difficult.

Sleeping through the night	Yes	No	Balancing on both feet	Yes	No
Dressing: Putting on or taking off shoes, socks, shirt, jacket or pants	Yes	No	Walking on: stairs, flat surfaces, inclines, uneven surfaces, ladders	Yes	No
Maintaining static position of; Head bent forward, arms overhead, arms forward, or turning head	Yes	No	Lifting	Yes	No
Getting in/out of: chairs, bed, car, or bath/shower	Yes	No	Carrying	Yes	No
Reaching: Overhead, behind back, downward or forward	Yes	No	Bending, kneeling, squatting	Yes	No
Gripping, holding tools or opening jars	Yes	No	Driving a vehicle or ability to use gas/brake pedals	Yes	No
Picking up small objects	Yes	No	Caring for child or adult	Yes	No
Sitting	Yes	No	Housework/ yard work	Yes	No
Recreational Activities	Yes	No	Have you fallen more than 1 time in the past year	Yes	No

<u>Additional Information</u>

Is there any other information you would like to provide about your condition/injury or medical history that we haven't already asked about ? _____

_____

_____

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