NOTE: # PATIENT HISTORY

This is a confidential record and will be kept in this office. Information contained herein will not be shared with anyone without your authorization to do so

Today's Date: ___/___/___
Last Name: _____ First Name: _____ M.I. ___
Date of Birth: ___/___/___

CHIEF COMPLAINT: What is the MAIN REASON for your visit today? (Describe in detail).

_____

_____

HISTORY OF PRESENT ILLNESS: Please answer the following questions by circling or explanation.

1. Location of the problem:

_____

2. On a scale of 0-10, (with 0 being normal and 10 being intolerable, 5 is uncomfortable but activity level is intact) circle the number that best describes your pain level at the problem area.

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

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

Average: 0 1 2 3 4 5 6 7 8 9 10

3. When did you first notice the problem?

___ days ago ____ weeks ago ____months ago

Other: _____

4. What movement/activity/position aggravates the pain?

_____

5. What movement/activity/position eases the pain?

_____

6. Check the BEST description of how your pain behaves.

a) ___ Worse in early morning, evening, overnight, OK day
b) ___ Best in morning, worse as day progresses
c) ___ Better or worse depending on my activity level
d) ___ Changes with the weather
e) ___ None of the above

7. Is the pain constant or variable? _____

8. Is the pain: Sharp Dull Throbbing

9. Does the problem interfere with your normal function? Name something you can no longer do due to the pain.

_____

10. Have you recently lost weight unexpectedly? Y N

INVESTIGATIONS:

X-rays: Y N Date: __/__/__ Findings: _____
MRI: Y N Date: __/__/__ Findings: _____
CT Scan: Y N Date: __/__/__ Findings: _____

Other: _____

PREVIOUS TREATMENT: **Please list previous treatments administered, e.g. Chiropractic, Physical Therapy, Acupuncture, injections, surgery… _____**

MEDICATIONS: **Please list all medications you are currently taking and rate effectiveness at reducing the pain.**

Medicine: _____ Effect: _____ Medicine: _____ Effect: _____
Medicine: _____ Effect: _____ Medicine: _____ Effect: _____
Medicine: _____ Effect: _____ Medicine: _____ Effect: _____

GENERAL HEALTH: **List any health conditions that may affect your ability to tolerate Physical Therapy treatment.**

_____

_____

Do you have a cardiac pacemaker? Y N Have you had a heart attack? Y N Do you experience angina? Y N