PHYSICAL THERAPY PAST MEDICAL HISTORY

Your chief complaint?

How and when did these symptoms first occur?

Briefly describe any previous injuries and the approximate date of injury:

Date: ____________________  Injury: ____________________

Date: ____________________  Injury: ____________________

Please list any medications/supplements you are currently taking:

Have you undergone any diagnostic tests for this condition?  (please check the appropriate responses)

X-ray  ______  MRI  ______  CAT Scan  ______

Other  ___________________________________

Do you have any tingling, numbness or loss of skin sensation?  Yes _____  No _____

If yes, please describe location ___________________________________

If yes, do you feel this is related to your current complaints?  Yes _____  No _____

Please rate the severity of the symptoms/pain you are currently experiencing:

Provide 3 ratings – When symptoms are at their best, at their worst, and currently

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No pain/symptoms  __________  __________  __________  __________  __________

Worst pain/symptoms  __________  __________  __________  __________  __________

Please check the words/phrases which describe your symptoms:

_____ dull ache  _____ sharp  _____ shooting

_____ stiffness  _____ constant  _____ on and off

_____ worse in a.m.  _____ worse in p.m.  _____ awakens you at night
Name ____________________________________________
Identification Number ____________________________________________
Date of Birth _____________ Phone Number ____________________

What increases your symptoms?

- stair climbing
- sitting
- walking
- athletics
- standing
- lying
- static positions
- Other __________________________________

What decreases your symptoms? ____________________________________________

Circle all that apply related to your Past Medical History:

- Cancer
- Diabetes
- Heart Issues
- Breathing Issues
- High/Low Blood Pressure
- Seizures
- Falls
- Heat/Cold Intolerance
- Surgery

Do you have any other Past Medical History? (please specify) ________________________________

Are you pregnant? _____ Yes _____ No

Does this condition cause you to have headaches? _____ Yes _____ No

How often? ________________________________

Have you had physical therapy before? _____ Yes _____ No

If yes, what did it include? __________________________________

What recreational or work-related activities do you engage in? ________________________________

What are your goals for Physical Therapy? __________________________________

Are you currently seeing any of the following?

- Medical Doctor Yes ___ No ___
- Chiropractor Yes ___ No ___
- Psychiatrist/Psychologist Yes ___ No ___
- Attorney Yes ___ No ___
- Other Physical Therapist Yes ___ No ___
- Other ________________________________

Signature ____________________________________________ Date ____________________

Reviewed by (therapist signature) ________________________________ Date ____________________