Name:

Physician:

(Office Use Only)

MDR

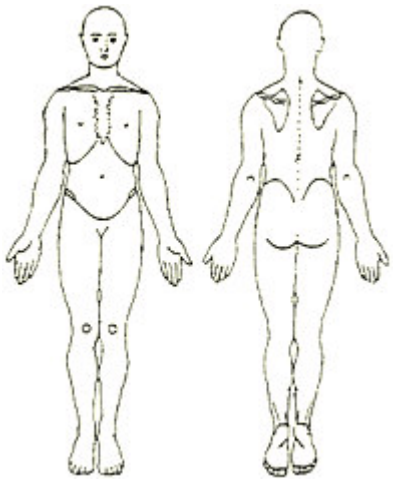
Physical Therapy

Dear Patient: Please provide us with this important health history information. If you don't understand a question, your therapist will assist you. Thank you.

1. For what condition are you seeking treatment here?_____
2. Date of onset of condition. _____
3. Cause of condition? _____
4. Have you been treated for this or a similar condition before? ☐ No ☐ Yes (Continue with the following)
   ☐ No Treatment ☐ Medical Doctor ☐ Chiropractor ☐ Exercise ☐ Medication
   ☐ Physical Therapy ☐ Heat / Ice ☐ Other: _____
5. What are your symptoms? ☐ Pain ☐ Numbness ☐ Weakness ☐ Tingling
   ☐ Loss of Motion ☐ Nausea ☐ Dizziness ☐ Other: _____
   *If you have pain, please complete this section, if not please skip to question 7.
6. A. Rate the average amount of pain you have using a "0" to "10" scale where "0" equals no pain and "10" equals the worst pain imaginable. Mark the line at the point that represents your pain.

   "0" ◄——————————————————————► "10"

   B. Please mark areas of pain on the diagram to the right...

   C. Is your pain getting: ☐ Better ☐ Worse ☐ Same
   Pain is: ☐ Constant ☐ Off ☐ On ☐ Various

   D. Time of day pain is worse: ☐ Upon Wakening
   ☐ A.M. ☐ Midday ☐ P.M. ☐ Late Night
   ☐ Sleep is disturbed ☐ Varies ☐ Same

   E. What makes the pain worse: ☐ Lie ☐ Sit ☐ Sit-Stand
   ☐ Stand ☐ Walk ☐ Bend ☐ Lift ☐ Stairs
   ☐ Reach ☐ Deep Breath ☐ Cough/Sneeze
   ☐ Rotate Trunk Left ☐ Rotate Trunk Right
   ☐ Turn Head Left ☐ Turn Head Right Other:_____

   F. Pain is better with: ☐ Medication ☐ Heat ☐ Ice ☐ Rest ☐ Position/Posture
   ☐ No Relief ☐ Other: _____
7. Diagnosis tests done? ☐ None ☐ X-ray ☐ MRI ☐ CT Scan ☐ Arthrogram ☐ Other:_____
8. On the job injury? ☐ No ☐ Yes - Light Duty?: ☐ No ☐ Yes - Restrictions:_____
9. Occupation _____ Physical Demand of Job: ☐ Lifting ☐ Sitting ☐ Phone
   ☐ Computer ☐ Overhead ☐ Driving ☐ Extended Standing
10. A. Exercise/Activity level prior to onset of condition: ☐ Walk ☐ Run ☐ Bike ☐ Swim
    ☐ Weight Train ☐ Aerobics Class ☐ Sport: _____ How many times per week? _____
    B. Exercise level now: ☐ None ☐ Reduced ☐ Same

11. A. Rate how near you are to your normal function level using a “0” to “10” scale where “0” equals not performing your normal activities at all and “10” equals doing all your normal activities without difficulty.

“0” ⟷ “10”

B. Which activities are limited? ☐ Recreation/Exercise ☐ Work ☐ Home / Daily Living

12. What are your goals for therapy: ☐ Reduce Pain ☐ Restore Function ☐ Return to Work

☐ Learn Self-Help Exercise Program ☐ Other: _____

13. Current stress level: ☐ Mild ☐ Moderate ☐ High ☐ Usual ☐ Increased

14. Medical History:

A. When was your last medical physical? _____ Months / Years

B. Have you been diagnosed or experienced any of the following?

☐ High Blood Pressure	☐ Arthritis	☐ Hepatitis
☐ Depression	☐ Emphysema	☐ Rheumatoid Arthritis
☐ Tuberculosis	☐ Sleep Disorder	☐ Bronchitis
☐ Fibromyalgia	☐ Kidney Disease	☐ Cancer / Tumor
☐ Asthma	☐ Ulcers	☐ Bowel/Bladder Problems
☐ Diabetes	☐ Stroke	☐ Deep Vein Thrombosis
☐ Anemia	☐ Thyroid Problems	☐ Epilepsy
☐ Fracture	☐ Weakness	☐ Dizziness / Blackouts
☐ Heart Condition	☐ Balance Problems	

☐ Muscle or Joint Problems i.e., Neck, Back, Knee _____

☐ Surgery: _____

☐ Other: _____

15. Which of the following medications have you taken in the last week?

A. Over the counter: ☐ Aspirin ☐ Decongestants ☐ Laxatives

☐ Tylenol ☐ Antihistamines ☐ Advil / Ibuprofen ☐ Vitamins / Minerals

☐ Other: _____

B. Prescription for: ☐ Pain ☐ Heart ☐ Blood Pressure

☐ Muscle Relaxants ☐ Antibiotics ☐ Lung/Breathing ☐ Steroids ☐ Hormones

☐ Stomach ☐ Anti-Inflammatory ☐ Other:_____

16.Have you had a recent (within last 2-3 mnths) change in : ☐ Appetite ☐ Weight ☐ Energy ☐ Balance

17. Do you regularly consume: ☐ Alcohol ☐ Caffeine ☐ Cigarettes

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I certify that the following information is complete, true and correct. I have been fully informed of and understand the nature and extent of the activity in which I will participate associate with the Physical Therapy and Performance Testing Program and I hereby consent to the same. I am aware of no physical or medical condition that I have that will in any way be adversely affected by or impaired my ability to fully participate in the services associated with this program.

_____ Therapist Signature

_____ Patient Signature

_____ Date