

PATIENT HISTORY FORM

Name: _____ Date: _____ Date of Birth: _____ Age: _____
Height: _____ Weight: _____ Injury Date or Date of Onset: _____

REASON FOR PHYSICAL THERAPY TREATMENT

Circle the body region(s) involved in your injury/disorder for which you are seeking physical therapy:

left leg/foot right leg/foot left arm/hand right arm/hand lower back
middle back upper back/neck upper neck/head other: _____

Have you received previous treatment for this condition? Yes No If yes, please circle all that apply:

medicine injections surgery chiropractic physical therapy other: _____

Severity of your pain? Mark the point on the line, 0 (least) and 10 (worst), which best describes your current pain level.

0 1 2 3 4 5 6 7 8 9 10

MEDICAL HISTORY

List your current medications: _____

List your past surgeries and dates: _____

List all allergies (medications, skin, tapes, latex) _____

List any recent traumatic injuries/surgeries _____

SOCIAL HISTORY

Your personal habits: Do you? NO YES If yes, how much?

Smoke _____
Drink alcohol _____

Please circle Yes or No if you have any of the following conditions? If yes, please explain.

Constitutional:

Recent weight changes N Y _____
Night sweats/pain, fevers N Y _____

Cardiovascular:

Chest pain/heart trouble N Y _____
Palpitations/murmurs N Y _____
High/low blood pressure N Y _____
Pacemaker N Y _____

Musculoskeletal:

Muscle pain/cramps N Y _____
Muscle weakness N Y _____
Stiffness/swelling joints N Y _____
Rheumatoid arthritis/Joint pain N Y _____
Broken bones N Y _____
Fibromyalgia N Y _____

Endocrine:

Hormone problems N Y _____
Diabetes N Y _____

Genitourinary:

Kidney stone N Y _____
Males: testicular pain N Y _____
Females: menstrual problems N Y _____
 Could you be pregnant? N Y _____

Gastrointestinal:

Nausea/vomiting N Y _____
Abdominal pain N Y _____
Bowel problems N Y _____

Neurological:

Frequent headaches N Y _____
Paralysis/tremors N Y _____
Convulsion/seizures N Y _____
Numbness/tingling N Y _____
Head/spinal injury N Y _____

Hematologic/Lymphatic

Bruise easily or slow to heal N Y _____

Eyes:

Eye disease/injury N Y _____

Psychiatric:

Insomnia N Y _____
Confusion/memory loss N Y _____
Depression N Y _____

Other:

Cancer N Y _____
HIV-AIDS N Y _____
Hepatitis N Y _____