Name:_____ **PATIENT HISTORY**

Primary Care /General Doctor: _____ **Height**: _____ **Weight**: _____
Date of Onset of Pain: _____ **Date of Injury:** _____ **Date of Surgery:** _____
Pain Status: □ New Injury □ Chronic Injury
What is your primary concern? _____
Pain Location: _____ **Treatment Side:** □ N/A □ Left □ Right

Pain Scale: 0= None 5= Moderate 10= Extreme

	0	1	2	3	4	5	6	7	8	9	10
At worst:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Current:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
At best:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aggravating Factors: ☐ Sitting ☐ Standing ☐ Walking ☐ Lying down
☐ Stairs – up ☐ Reaching ☐Lifting ☐ Getting up from a chair

What makes it feel better? _____ **Feel worse?** _____
History of Similar Symptoms: ☐ No ☐ Yes **History of Falls in last year:** ☐ No ☐ Yes
Home Health Care: ☐ No ☐ Yes **Hospitalization in last 3 months?** ☐ No ☐ Yes
Occupation: _____

Medical History:	☐ Fracture or Suspected Fracture	☐ Rheumatoid Arthritis
☐ Alzheimer's	☐ High Blood Pressure	☐ Traumatic Brain Injury
☐ Cardiovascular Disease	☐ History of Cancer	☐ Allergies: _____
☐ Cauda Equina Syndrome	☐ Huntington's	☐ Unexplained Weight Loss
☐ CVA / Stroke	☐ Immunosuppression	☐ Pacemaker
☐ Current Infection	☐ Lupus	☐ Pregnant
☐ Diabetes Mellitus Type 1	☐ Muscle Dystrophy	☐ Seizures
☐ Diabetes Mellitus Type 2	☐ Osteoarthritis	☐ HIV/AIDS
☐ Hemophilia	☐ Hepatitis B/C	☐ Other: _____

Diagnostics: ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Myelogram ☐ Diagnostic Ultrasound
Results of Imaging: _____
Medications: ☐ See attached _____
_____
Patient Goals for Physical Therapy: _____
_____

Patient Signature_____ **Date**_____

_____