Medical History

OUTPATIENT PHYSICAL THERAPY

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up to date background information.

Name: _____ **Age:**_____ **Occupation:**_____

Date of injury or onset:_____ **Date of Surgery:**_____ **Next Doctor's Visit:**_____ **Height:**_____ **Weight:** _____

1) What do you think caused your symptoms?:_____

2) Please list special tests performed on this problem (x-ray, MRI, lab): _____

3) Have you ever had this problem before? _____ When? _____ Treatment rec'd?_____

If yes, how long did it take for you to feel better?_____

Instructions: Please mark on the diagram to the right to indicate where you feel symptoms right now.

4) Please describe your Symptoms:

_____

_____

_____

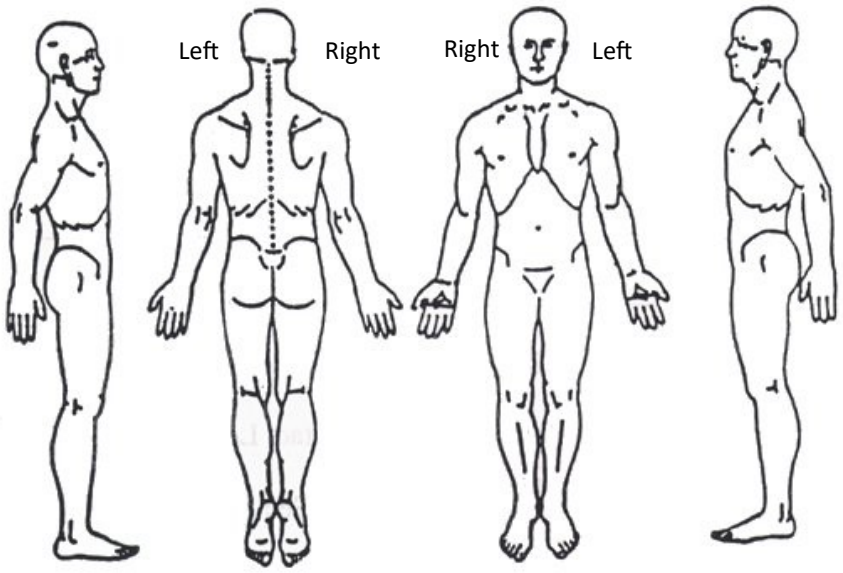
_____

_____

_____

_____

_____



5) My symptoms are currently:

- ☐ Getting Better
- ☐ Getting Worse
- ☐ Staying about the same

6) My symptoms currently:

- ☐ Come and go
- ☐ Are constant
- ☐ Constant, but change with activity

7) Currently, are you able to sleep due to symptoms?

- ☐ No problem sleeping
- ☐ Difficulty falling asleep
- ☐ Awakened by pain
- ☐ Sleep only with medication

8) When are your symptoms worst?

- ☐ Morning ☐ Afternoon
- ☐ Evening ☐ Night
- ☐ After exercise

9) When are your symptoms best?

- ☐ Morning ☐ Afternoon
- ☐ Evening ☐ Night
- ☐ After exercise

10) At the present time, would you say your health is:

- ☐ Excellent ☐ Good
- ☐ Fair ☐ Poor

11) Aggravating Factors: Identify up to 3 important positions or activities that make symptoms worse:

1._____
2._____
3._____

12) Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1._____
2._____
3._____

13) What are your goals for therapy?

1._____
2._____
3._____

14) Using the 0 to 10 scale, with 0 being no pain and 10 being the worst pain imaginable please describe:

Your current level of pain while completing this survey:_____
The best your pain has been the past 24 hours _____
The worst your pain has been the last 24 hours_____

15) Personal health history (check all that apply):

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD), ARDS, or emphysema
- ☐ Angina
- ☐ Congestive heart failure (or heart disease)
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Neurological disease
- ☐ Stroke or TIA
- ☐ Peripheral Vascular Disease
- ☐ Headaches
- ☐ Diabetes– Type I and II
- ☐ Gastrointestinal Disease
- ☐ Seizures
- ☐ Visual Impairment
- ☐ Hearing Impairment
- ☐ Back Pain/ Neck Pain
- ☐ Kidneys, bladder, prostate issues
- ☐ Previous accidents
- ☐ Allergies
- ☐ Incontinence
- ☐ Anxiety or Panic Disorder
- ☐ Hepatitis, TB, HIV, Aids
- ☐ Prosthesis/ Implants
- ☐ Cancer
- ☐ Latex allergy
- ☐ Have a pacemaker
- ☐ Pregnant
- ☐ Smoker
- ☐ Other: _____

16) Have you recently experienced the following?

- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Weightloss/gain
- ☐ Muscle weakness
- ☐ Fainting
- ☐ Difficulty maintaining balance while walking
- ☐ Falls
- ☐ Dizziness/ Lightheadedness
- ☐ Heartburn/Indigestion
- ☐ Difficulty swallowing
- ☐ Bowel or bladder changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Cough
- ☐ Headaches

17) Over the last 2 weeks how often have you been bothered by any of the following problems:

☐ Feeling down, depressed or hopeless? ☐ Bothered by, have little interest or pleasure in doing things?

Is this something with which you would like help? ☐ Yes ☐ Yes, but not today ☐ No

18) Medications: This includes prescriptions, over the counter drugs, herbal and nutritional supplements. Separate list provided? Yes No **If not, please complete the section below.**

Medication/Drug Supplement/Vitamin:	Dosage:	Route of Administration:	Is this a Prescription?	Frequency Per Day:

19) Please list any recent surgeries or hospitalizations including dates:

_____

_____

20) Other:

Are you currently in a Skilled Nursing Home?	No	Yes
Are you receiving any Home Health Services?	No	Yes
Is injury a result of a fall in the past year?	No	Yes
Have you fallen 2 or more times in the past year?	No	Yes

21) Are you covered:

Under Black Lung Disease?	No	Yes
End Stage Renal Disease?	No	Yes
Large Group Insurance?	No	Yes
Veterans Affairs?	No	Yes