Patient History

Name: ____ Age: ________

To ensure you receive a complete and thorough evaluation, please provide us with important background information by answering the following questions.

Do you currently have any of the following?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Diabetes			Open Wounds			Fatigue		
Arthritis			Current Infection(s)			Headaches		
Osteoporosis			Anxiety			Nausea / vomiting		
High Blood Pressure			Fever/chills/sweats			Pacemaker		
Change in weight in past month for no reason?						Latex allergy		
Change in bladder or bowel functions?						Are you pregnant?		
Does pain wake you up when you sleep?						Surgical Implant?		
Other:								

Did you ever have any of the following?

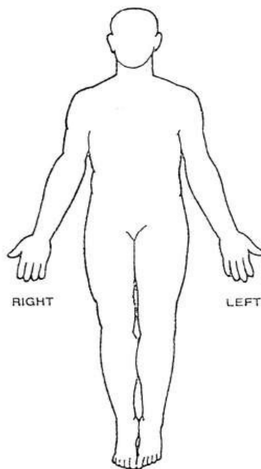
Heart Disease			Vascular Disease			CVA / Stroke		
Cancer / Tumor			Seizures			Other:		
Recent Surgeries:								

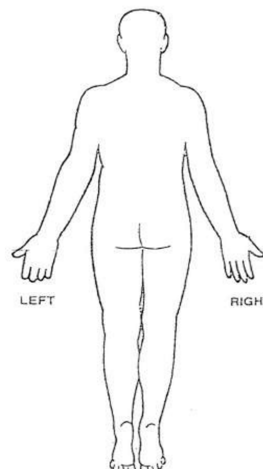
Please tell us more about your present symptoms / condition:

1. What are the symptoms that brought you into PT? ______________________________
2. When did it start? Date? __________
3. Where did it start? ❑home ❑work ❑car accident ❑other:____________________
3. Have you ever been hospitalized for this condition? ❑ No ❑ Yes, How long? __________
4. Are you taking any medications? ❑ No ❑ Yes, What type? ____________________
5. How much of your daily activities are you able to do now on a scale from 0 to 100%? ________
6. When is your next MD appointment? __________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Include all affected areas. Just to complete the picture, please draw in your face.

Ache ^^^ Numbness **===** Pins & Needles **ooo** Burning **xxx** Stabbing **///**





PAIN RATING SCALE

Please rate the severity of your pain by circling a number between 0 and 10.

0 1 2 3 4 5 6 7 8 9 10

no pain — moderate pain — strong pain — very strong pain — unbearable pain

revision 7/17/09