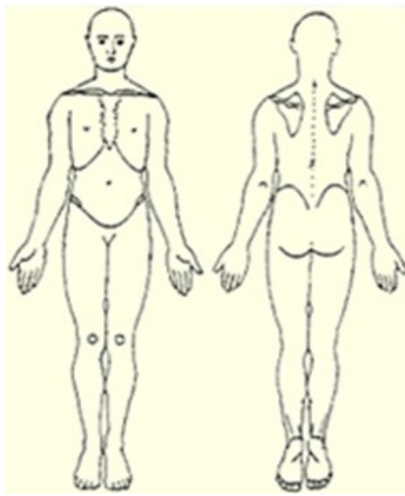


MEDICAL HISTORY AND PHYSICAL CONDITION

BMI—Office Use Only W _____ # H _____ Inches
--

Patient Name: _____

- Please describe the problem indicated on your prescription: _____
- Please give approximate date when symptoms first appeared: _____



Where is your pain? _____

Is your pain _____ constant or _____ intermittent?

Describe your pain: _____

Pain Scale: No pain = 0 1 2 3 4 5 6 7 8 9 10 = **Worst possible**

Worst pain level = _____ Current pain level = _____ Lowest pain level = _____

Please mark the chart to the left if/where you are experiencing:

P=Pain N= Numbness T= Tingling W= Weakness

- If you have pain/symptoms in more than one area, which area is worst? _____
- Do you have difficulty voiding or controlling bowel/bladder? Yes No
- When are symptoms worse? Morning Afternoon Evening Night Sleep Disturbed
- What makes your symptoms **worse**:
 - Coughing Sneezing Bending Lifting Head Movement Arm Movement
 - Sitting—how many minutes ____ Standing—how many minutes ____ Walking— how many minutes ____
 - Other: _____
- What makes your symptoms **better**:
 - Sitting—how many minutes ____ Standing—how many minutes ____ Walking— how many minutes ____
 - Bending forward Lying down on my Side Back Stomach
 - Other: _____
- Have you ever had these symptoms in the past? Yes No If so, when? _____
- Are your symptoms: Getting worse Getting better Staying the same
- Have you had any treatment for this problem?
 - Injections** When? _____ Helpful? Yes No
 - Physical Therapy** When? _____ How many treatments? _____ Helpful ? Yes No
 - Chiropractic** When? _____ How many treatments? _____ Helpful ? Yes No
 - Surgery** When? _____ Type _____ Helpful ? Yes No
 - Other** _____
- Have you had any diagnostic tests for this problem?
 - X-rays / When? _____ Bone Density / When? _____ CT Scan / When? _____
 - MRI / When? _____ Nerve Conduction Velocity Test / When? _____
 - Other _____

Current and Past Medical History (Please check all that apply)

- Allergies
- Balance Difficulties
- Cardiac Arythmia
- Cognitive Impairments
- Diabetes
- Dizzy Spells
- Depression
- High Blood Pressure
- Headaches
- Hearing Problems
- Hernia
- HIV/AIDS
- Heart Attack
- Heart Problems / What type _____
- Kidney Disease
- Lung/Breathing Problems
- Osteoporosis
- Pacemaker
- Pregnancy
- Seizures
- Stroke
- Vascular Disease
- Vision Problems
- Broken Bones _____
- Long-term steroid use (3 mos.)
- Motor Vehicle Injury/When _____
- Other Injury/What _____
- Cancer: Type _____ When _____ Current Status _____
- Did you have: Chemotherapy Radiation Surgery

12. Do you have any metal implants?

- Hip (R / L)
- Knee (R / L)
- Back
- Shoulder (R / L)
- Other _____

13. What is your occupation? _____

Employed: Full-time Part-time Not currently working

Out of work since: _____ Plan to return to work on: _____

14. Is there litigation involved with your problem? Yes No

15. What type of regular exercise do you do? _____

16. Do you smoke? _____

17. Please list medications and dosage you are taking or provide a list for our records:

Medication	Dosage

Medication	Dosage

18. What are your expectations / goals for Physical Therapy?

If you are a Medicare patient, have you recently had care from a Home Health Agency? _____

If so, please provide the name of your Health Care Provider: _____

Name of Home Health Agency: _____ Phone: _____

Address: _____

Date of discharge from Home Health Agency: _____

Have you had ANY other Physical Therapy or Speech Therapy ANYWHERE this year? _____

The above information is correct, complete and to the best of my knowledge

Signature

Date