



**HANDS-ON
PHYSICAL THERAPY**

GENERAL PATIENT INFORMATION

Today's Date _____

Name _____ D.O.B. _____ Age _____ Sex _____

Occupation _____ Height _____ Weight _____

Name of referring physician: _____ Date of most recent examination: _____

Date of next appointment with referring physician: _____ Please list the names of physicians, therapists, or other practitioners previously seen for this condition: _____

Please list all current medications (including non-prescription meds): _____

MEDICAL HISTORY

Please circle if you have had or have any of the following:

- | | | |
|-------------------------|-------------------------------------|--|
| 1) Heart Disease | 9) Cancer | 17) Weakness |
| 2) Stroke | 10) Changes in bowel/bladder habits | 18) Fainting |
| 3) Respiratory Problems | 11) Changes in eating pattern | 19) Dizziness |
| 4) Diabetes | 12) Changes in sleeping pattern | 20) Night Pain |
| 5) Arthritis | 13) Unexplained weight loss | 21) Shortness of Breath |
| 6) Allergies | 14) Depression | 22) Sexual Difficulty |
| 7) High Blood Pressure | 15) Nausea/Vomiting | 23) Smoking and/or substance abuse |
| 8) Fever/Chills/Sweats | 16) Numbness | 24) Mental Illness/ Psychological Consultation |

Please include additional information about circled items for clarification: _____

Have you ever had surgery? If yes, please list all surgeries and dates: _____

Please list Family Medical Problems: _____

CONTRIBUTING FACTORS

Please circle one or more of the following problems if possibly relative to your present condition.

- | | | | |
|------------|----------------------------|---------------------------------|-------------------|
| 1) Injury | 3) Virus or flu just prior | 5) Sustained or unusual posture | 7) Heavy lifting |
| 2) Illness | 4) Overtired just prior | 6) Unusual activity | 8) Immobilization |

Please include additional information for clarification: _____

MEDICAL TESTING (special tests relative to patient's current problem)

If you have had any of the following tests, please provide the date performed and your interpretation of the results.

- | | | |
|-------------------|-------------------------|----------------------------|
| 1) X-ray _____ | 4) Electromyogram _____ | 7) Blood/Urine tests _____ |
| 2) MRI scan _____ | 5) Myelogram _____ | 8) Stress Test _____ |

Symptoms

A. NATURE OF SYMPTOMS

- 1) Chief complaint: _____
- 2) Severity of discomfort at present time (please rate by circling the appropriate number)
0 1 2 3 4 5 6 7 8 9 10
No pain _____ Worst pain you have ever experienced in your life _____
- 3) Onset
 - a. WHEN did your pain begin (Please provide date) _____
 - b. Was the onset of your pain sudden _____ gradual _____ other _____?
 - c. WHERE and how did it begin (activity and specific cause)

 - d. Which of the following describes your problem?
Worse _____ Better _____ Not Changing _____
 - e. Just before this onset, were you completely free of discomfort where you have it now? _____
 - f. If not, please list the date and cause of injury and duration and treatment of prior episodes. _____

- 4) Description of discomfort:
 - a. Ache _____ pain _____ other _____
 - b. Sharp _____ dull _____ other _____
 - c. Paresthesia (strange sensations): pins and needles _____ numbness _____
tingling _____ burning _____ other _____ none _____
 - d. Throbbing _____ cramping _____ other _____

B. BEHAVIOR OF SYMPTOMS

- 1) Which of the following describes your discomfort?
Constant _____ Intermittent _____
 - a. If intermittent, how often does it recur? _____
 - b. When it recurs, how long does it last? _____
 - c. How long can you be free of discomfort? _____
- 2) Describe your discomfort over a typical day (i.e. better/worse in the morning, noon, or night)

- 3) What activities or positions aggravate your problem? _____

- 4) Functionally, what activities are difficult to do because of your problem (i.e. vacuuming, brushing hair, climbing stairs, etc) _____
- 5) What activities or positions relieve your problem? _____

- 6) Do you experience discomfort when you cough or sneeze? _____
- 7) Effect of rest:
 - a. What is the effect of rest on your discomfort?
Relieves ___ makes worse ___ no change ___
 - b. Does your discomfort ever wake you at night? _____
If yes, describe how often, and if you can get back to sleep

8) Location:

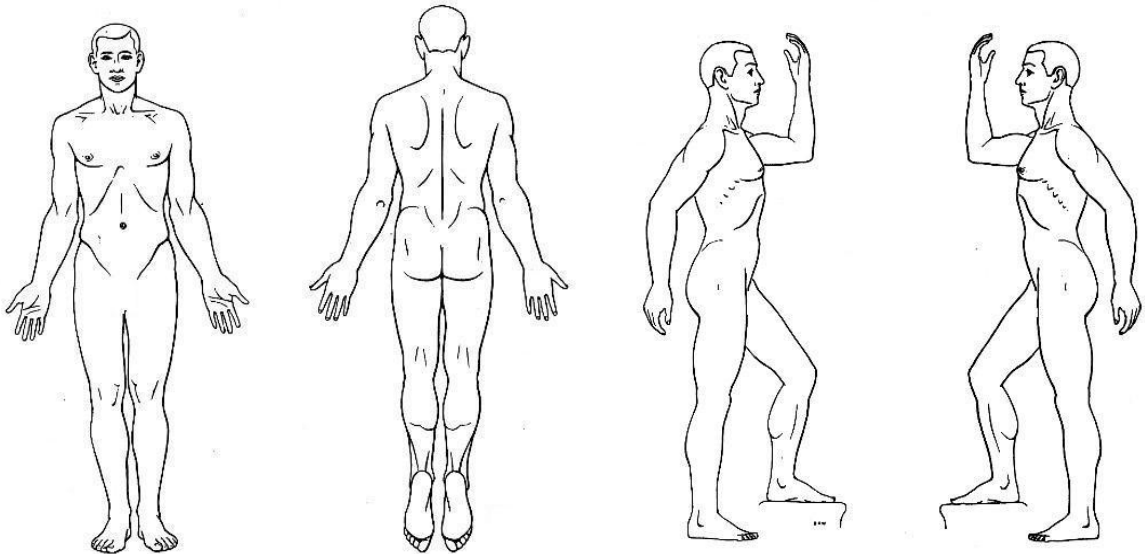
a. **Present:** Exactly where is your discomfort? Mark those areas on the body diagram that represents the location of your symptoms. Draw the following symbols onto the body diagrams to indicate the location and intensity of pain or numbness.

√√√ Minimal to Moderate Pain

□□□ Severe Pain

→→ Radiating Pain

xxx Numbness



b. **Past:**

i. When your problem began, was your discomfort in exactly the same location as you have it now? _____

ii. If the position of the comfort has changed, how did the position of the discomfort progress from the original location? _____

C. IS THERE ANYTHING ELSE RELATED TO YOUR PROBLEM THAT HAS NOT BEEN COVERED? _____

D. WHAT ARE YOUR GOALS? _____

E. DO YOU EXERCISE REGULARLY? YES / NO If yes, what is your primary activity? _____

F. HAVE YOU HAD PREVIOUS PHYSICAL THERAPY? YES / NO If yes, where? _____

1. What was the outcome? _____
