Patient Information and Medical History Sheet

Name:	Today's date:
Address:	Phone #:
City/State:	Email:
Zip Code:	Date of birth: / /

Primary Care Physician:	Phone #:

Married _____ Single_____ Divorced_____ Significant Other_____	
Work: Full Time____ Part time: ____ Retired:____	Occupation:
Do you live: alone____ or with others who can assist you ____	Primary Language: English ___ Other_____
Do you have stairs in your home: Yes___ No___	
Are you a caregiver to: Children____/ Adult____	
Emergency Contact Name:	Phone:

Leisure activities	

Name of person responsible for payment:	
Insurance name:	
Member number:	Member date of birth:
Group number:	

Have you ever had physical therapy?	Y N	What were you seen for?
Do you exercise regularly?	Y N	What activities?
Is there a chance you are pregnant?	Y N	
Have you ever had massage therapy?	Y N	
Current Height: _____ Ft _____Inches		Current Weight: _____lbs
Do you have any difficulties with daily activities?		Please list any:

Do you take any prescription medications, over the counter medications and/or supplements daily?	Y N	Please list
Do you get regular sleep?	Y N	Comment:
Do you smoke?	Y N	If yes, what amount?
Do you drink?	Y N	If yes, how frequent?
Do you have any allergies?	Y N	List:
Do you have any implants?	Y N	List:
Have you had any type of surgery?	Y N	List date and type:

Past Medical History: mark an X next to any that apply:

HIV		Disease of bones/osteoporosis	
Cancer		Disorders of the spine	
Asthma		Disease of the joints	
Anemia		Rheumatoid arthritis	
Diabetes		Disorders of the muscles	
Disorders of the reproductive system		Long term steroid treatment	

Diseases of the liver		Multiple sclerosis	
Diseases of the lungs		Hernia	
Diseases of the gastrointestinal system		Seizure/Epilepsy	
Diseases of the circulatory system		Stroke	
Diseases of the kidney		Neurological disorders	
Heart disease or heart surgery or pacemaker		Do you bruise easily	
Hypertension (High blood pressure)		Vision disorders	
Migraines/headaches		Balance or vestibular disorders	
Rheumatic		History of a blood clot	
History of broken bone		History of any trauma	

If you answered yes to any of the above, please note them in detail below:

Why are you requesting to be seen by Physical Therapist today?

Patient signature_____

Pain/Discomfort Assessment

Is the pain: Constant_____ Intermittent_____ Only with movement_____

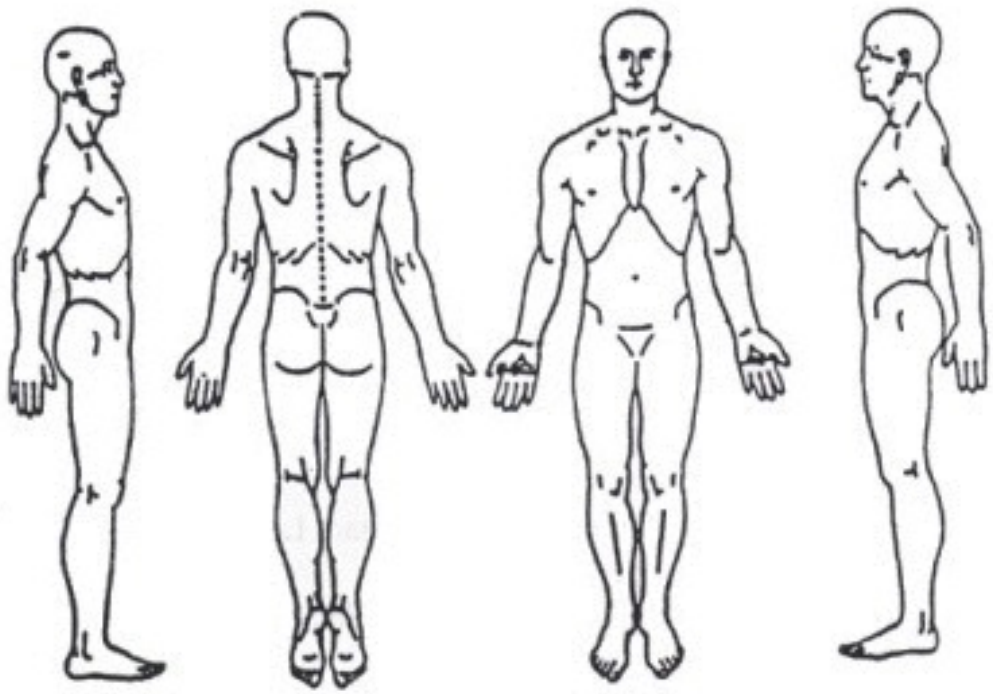
Rate the pain on a scale of 0-10 (10 being the worse)

0 1 2 3 4 5 6 7 8 9 10

How would you best describe your pain/discomfort?

Numbness ___ Tingling___ Dull/Aching___ Sharp___ Burning___ Stiffness___

Shade in the body diagram below to indicate where you have pain and discomfort



Does the pain radiate? Y____ N_____ If so, where?

_____

What activities make your pain better?

_____

What activities make your pain worse?

_____