

Date: _____ Name: _____
 DOB: _____ Acct: _____
 Insurance: _____

Patient Health History and Information

Date: ___/___/___ Age: _____ Height: _____ Weight: _____ Dominant hand: R L Could you be or are you pregnant: Yes No
 Sex: M F Reason for Therapy: _____

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown): _____

Date of injury or onset of symptoms: ___/___/___ Recent surgery? Yes No Date: ___/___/___ Type: _____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor): _____

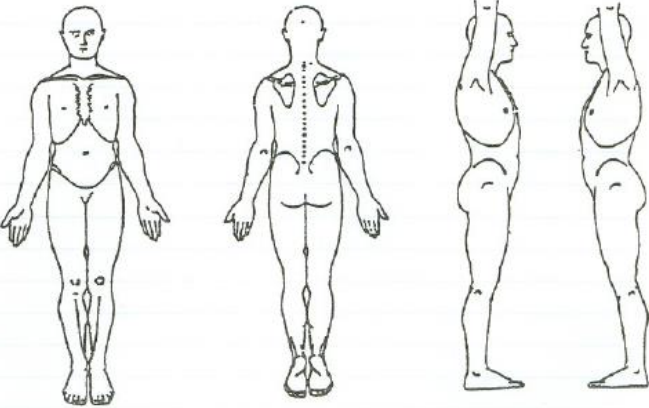
For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: ___/___/___ Surgery: type: ___/___/___ Other: ___/___/___

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain // = Numbness

O=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe your pain/symptoms

Constant	Intermittent	Increasing
Decreasing	Staying the same	
Sharp	Dull	Aching
Weakness	Throbbing	Other: _____

Which side are we seeing you for?: Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity) _____

What makes your symptoms better? (i.e. heat, cold, rest, activity) _____

Please indicate your current limitations due to injury:

- | | | |
|---------------------------------|-------------------------------|--|
| ___ Sitting: _____ | ___ Standing: _____ | ___ Sleeping: _____ |
| ___ Going from sit to stand | ___ Walking _____ | ___ Lying down |
| ___ Reaching _____ | ___ Squatting | ___ Up/Down stairs |
| ___ Taking a deep breath | ___ Swallowing | ___ Bending |
| ___ Turning head | ___ Driving | ___ Looking overhead |
| ___ Self care / Hygiene _____ | ___ Home activities _____ | ___ Talking / Chewing / Yawning / All (circle one) |
| ___ Repetitive activities _____ | ___ Sports / Recreation _____ | ___ Work |
| ___ Other: _____ | | |

What are your goals for therapy? _____

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No	Unexplained weight change	Yes	No
Nausea / Vomiting	Yes	No	Night sweats / pain	Yes	No
Numbness genital/anal area	Yes	No	Problems with vision / hearing / speech	Yes	No
Dizziness / Fainting	Yes	No	Difficulty with bowel/bladder function	Yes	No
Unexplained weakness	Yes	No	Other: _____	Yes	No
Headaches	Yes	No			

Who referred you to Physical Therapy? _____

Primary Physician: _____

How did you hear about Creekside Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

Date: _____ Name: _____

D.O.B. _____ Patient Account _____

Insurance: _____

GENERAL HEALTH HISTORY:

Have you had any falls or near falls in the past year? ____ Yes ____ No

Rate your overall health: Excellent Good Average Poor Do you exercise? Yes No ____x/week

Do you smoke? Yes No Do you drink caffeinated beverages? Yes No # ____/Day

Rate your Stress Level: Low Medium High Medications: see attached list

Occupation/job title: _____ Self Student Full time Part time Retired Unemployed

Living Situation: Alone Spouse Family Others

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other: _____

Employer: _____ Current work duty: Full duty Restricted duty Work days missed: _____

List previous surgeries: _____

Have you or anyone in your immediate (brother, sister, parent, grandparent) family ever been diagnosed with any of the following:

Allergies/asthma	Self	Family	No	Kidney problems	Self	Family	No
Cancer	Self	Family	No	Thyroid problems	Self	Family	No
High blood pressure	Self	Family	No	Epilepsy/dizziness	Self	Family	No
Heart trouble/angina	Self	Family	No	Tuberculosis	Self	Family	No
Diabetes	Self	Family	No	Anemia/blood disorder	Self	Family	No
Stroke	Self	Family	No	Multiple Sclerosis	Self	Family	No
Osteoporosis	Self	Family	No	Circular/vascular problems	Self	Family	No
Osteoarthritis	Self	Family	No	Chemical dependency	Self	Family	No
Rheumatoid arthritis	Self	Family	No	Pace maker/metal implants	Self	Family	No
Depression	Self	Family	No	AIDS/HIV	Self	Family	No
Headaches	Self	Family	No	Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No	Lung Problems	Self	Family	No
Stomach/GI Problem	Self	Family	No	Other	Self	Family	No

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: 0- Not at all 1- Several days 2- More than half the days 3- Nearly every day
2. Feeling down, depressed or hopeless: 0- Not at all 1- Several days 2- More than half the days 3- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not effect your ability to benefit from physical/occupational therapy treatment: ____Yes ____No _____

Patient Signature: _____ Date ____/____/____

Reviewed by Therapist: _____ Date ____/____/____

MD follow-up: ____/____/____ None Scheduled

With-in 90days of last Medical history completion (date and initial any changes)

– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature: _____ Date ____/____/____

Reviewed by Therapist: _____ Date ____/____/____