PHYSICAL THERAPY PATIENT HISTORY

Name:

Last First MI Jr./Sr., etc

Age: _____

Sex: Male □ Female □

Language: □ English Understood
□ Interpreter Needed
□ Language spoken most often
_____

Hand Dominance:
□ Right Handed
□ Left Handed

EMPLOYMENT / WORK STATUS

□ Working full-time outside of home
□ Working part-time outside of home
□ Working full-time from home
□ Working part-time from home
□ Homemaker
□ Student
□ Retired
□ Unemployed

GENERAL HEALTH STATUS

Please rate your health:
□ Excellent □ Good □ Fair □ Poor

Family History (and relation to you):
□ Heart Disease_____
□ Hypertension_____
□ Stroke _____
□ Diabetes_____
□ Cancer_____
□ Psychological_____
□ Arthritis_____
□ Osteoporosis_____
□ Other_____

SOCIAL & HEALTH HABITS

a) Smoking? Yes □ No □
packs/day _____
cigars/pipes a day_____
Smoked in past? □ Yes □ No
Year Quit _____

b) Alcohol
#days/ week you drink on average_____
# of drinks you have on average day_____

c) Exercise
Do you exercise beyond daily activities and chores?
Yes (describe exercise) _____
days/ week you exercise_____ # Minutes___
No exercise _____

Other Clinical Tests in Past Year

□ MRI □ Biopsy □ EKG □ Blood test
□ CT Scan □ Bone Scan □ X-rays □ Stress test
□ NCV/EMG □ Myelogram □ Urine test

Medical / Surgical History

Check if you have or have had:

Arthritis _____
Fractures _____
Growth Problems _____
Allergies _____
Thyroid Problems _____
Cancer _____
Infectious Diseases _____
Kidney Problems _____
Ulcers _____
Skin Diseases _____
Depression _____
Pacemaker _____
Other _____

Seizures _____
Osteoporosis _____
Blood Disorders _____
Circulatory Problems _____
Heart Problems _____
High Blood Pressure _____
Lung Problem _____
Stroke _____
Diabetes _____
Hypoglycemia _____
Multiple Sclerosis _____
Muscular Dystrophy _____
Parkinson's Disease _____

Other Medical Care

Are you seeing anyone else for your problem?

_____

Functional Status

Difficulty walking up stairs _____
Difficulty getting in and out of bed _____
Difficulty getting up from a chair _____
Difficulty on level ground _____
Difficulty walking up or down inclines ____
Difficulty bathing or dressing _____
Difficulty with house chores _____

Have you ever had surgery? Yes ___ No ___

1)Date:_____Surgery_____

2)Date:_____Surgery_____

3)Date:_____Surgery_____

4)Date:_____Surgery_____

Additional Comments:

_____

_____

_____

_____

Within the past year, have you had these symptoms?

Chest Pain _____
Heart Palpitations _____
Shortness of Breath _____
Dizziness/Blackouts _____
Loss of Balance _____
Generalized Weakness _____
Difficulty Sleeping _____
Nausea/Vomiting _____
Weight loss/gain _____
Coordination Problems _____
Pain at night _____

Difficulty Swallowing _____
Bowel Problems _____
Urinary Problems _____
Headaches _____
Vision Problems _____
Hearing Problems _____
Cough/hoarseness
Loss of appetite _____
Fever chills/sweats _____
Joint pain or swelling _____

Current Condition/Chief Complaint

Describe the problems for which you seek physical therapy:

_____

_____

_____

Date of onset _____