PHYSICAL THERAPY
& WELLNESS CENTER

PATIENT HISTORY FORM

Date: ______ /______ / ______

Patient Name: ______________________________ Referring Physician: ______________________________

Home / Cell Phone: ______________________________ Work Phone: ______________________________

Date of Birth: ______ /______ / ______ Age: __________ Hand Dominance: ☐ Right ☐ Left

1. What is the problem/diagnosis we are seeing you for? ______________________________

2. When did it begin? ______ /______ / ______

3. Which of the following best describes how your problem/injury began?
   ☐ Lifting ☐ Trauma ☐ Overuse
   ☐ Car Accident ☐ Degenerative Process ☐ Unknown
   ☐ A Fall ☐ Recreational/Sports ☐ Other: ______________________________

4. Where did your injury/problem occur?
   ☐ Auto ☐ Work ☐ Home ☐ Other Premise ☐ Unsure ☐ Other: ______________________________

5. Have you retained an attorney? ☐ No ☐ Yes If yes, are you in litigation? ☐ No ☐ Yes

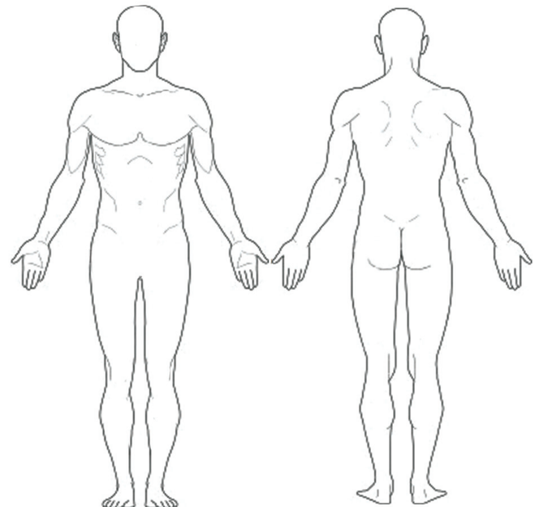
6. Please check any of the following symptoms that you are experiencing.
   ☐ Pain ☐ Limited Motion ☐ Numbness/Tingling ☐ Swelling ☐ Weakness ☐ Other: ______________________________

7. Please rate your pain on a scale of 0 to 10 *(Zero = No pain, 10 = Unbearable)*: _______________

   Rate your pain on a scale of 0 to 10 with the following activities:

   Walking: ______
   Standing: ______
   Sitting/Driving: ______
   Bending: ______
   Sleeping: ______
   Changing Positions: ______
   Lifting: General: ______
   Laundry Baskets: ______
   Groceries: ______
   Reaching Over the Head: ______
   Reaching Behind the Back: ______
   Looking Over the Shoulder: ______

   Shade any painful areas:



8. Does your pain wake you at night? ☐ No ☐ Yes
   What position do you normally wake in? ____________________ What is your preferred sleep position? ________________

9. Have you had similar problems in the past? ☐ No ☐ Yes If yes, when? ______________________________

10. What makes your symptoms worse?
    ☐ Weather ☐ Prolonged Activity ☐ Time of Day ☐ Certain Positions ☐ Other: ______________________________

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11. What relieves/lessens your symptoms?
☐ Medication ☐ Rest ☐ Heat ☐ Ice ☐ Exercises ☐ Other:____________________

12. What previous treatments have you had?

☐ None	☐ Medication	☐ Massage Therapy
☐ Physical Therapy	☐ Bracing/Taping	☐ Manipulation/Adjustment by a Chiropractor or Osteopath
☐ Injections	☐ Exercise	☐ Other: ____________________
☐ TENS unit		

13. Check if you have had any of the following tests for this problem within the last 6 months.

☐ MRI	☐ Arthroscopic Eval	☐ Bloodwork
☐ CT Scan	☐ EKG	☐ EMG
☐ X-Ray	☐ Myelogram	☐ Other: ____________________

14. Have you had any surgeries? ☐ No ☐ Yes If yes, please list type(s) and date(s):

____

____

Were any of the above tests or surgeries for the problem we are seeing you for? ☐ No ☐ Yes

15. Are you currently working? ☐ No ☐ Yes ☐ Part Time ☐ Full Time ☐ Restricted Duty
Occupation (specific): ______________________________
Are there any job tasks you are having difficulty with?____________________

16. List any medications you are taking (include over the counter)

____

17. Do you have any drug allergies? ☐ No ☐ Yes If yes, please list:

____

18. Are you allergic to latex? ☐ No ☐ Yes

19. Have you had, or do you currently have, any of the following medical conditions:

☐ Cancer	☐ Seizures	☐ Hernia
☐ Heart Disease	☐ CVA/Stroke	☐ Recent Surgery (this year)
☐ Diabetes	☐ Breathing Difficulties	☐ High Blood Pressure
☐ Joint Replacement	☐ Pacemaker	☐ Gout
☐ Pregnant (currently)	☐ Arthritis Type(s):______	☐ Other:____________________

20. What goals do you wish to achieve from Physical Therapy?

____

____

Thank you for completing this questionnaire.