Current Medical Condition

Patient Name: _____

Body part hurt/injured: _____

How were you injured? _____

Date of injury/onset (MM/DD/YY): _____ Date of surgery? (MM/DD/YY): _____

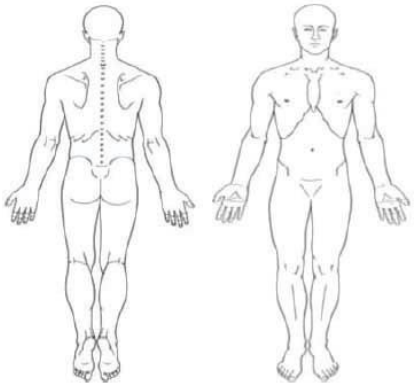
Students: What school do you attend? _____

Have you received physical therapy treatment this year? YES NO If yes, when? _____

Have you fallen in the last 12 months? YES NO If yes, when? _____

Patient Pain Assessment

Indicate where your pain is located using the pictures below



Chief Complaints / Problem List: _____
_____

What makes your symptoms better? (Ex. Rest, medication) _____
_____

What makes your symptoms worse? (Ex. Lifting, sitting, bending, stairs, squatting, kneeling) _____
_____

Pain Scale

Please use the number scale to rate your pain level

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain

CURRENT pain level _____ Pain at its **WORST** _____ Pain at its **BEST** _____

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____

Revised: 10/5/2022

Patient Medical History

Patient Name: _____ Date: _____

Referring Physician: _____ Family/Primary Care Provider: _____

Age: _____ Height: _____ Weight: _____

Medical Conditions

Do you have any medical condition you currently suffer from or have experienced in the past?* ○ Yes ○ No

List of Medical Conditions

Please indicate any medical conditions you currenlty suffer from or have experienced in the past

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type II	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed Head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD
☐ Asthma	☐ Congestive Heart Failure	☐ GERD	☐ Irritable Bowel Syndrome	☐ Rheumatoid Arthritis
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint pain	☐ Scoliosis
☐ Blood Clotting Disorder	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraine Headaches	☐ Shortness of Breath
☐ Cancer	☐ Degenerative Disc Disease	☐ Hepatitis B	☐ MRSA	☐ Sleeping Disorder
☐ Carpal Tunnel Syndrome	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB
☐ Cellulitis	☐ Diabetes Type I	☐ Hiatal Hernia	☐ Myocardial Infarction	☐ Urinary Incontinence

Other Conditions

Do you have a pacemaker ○ Yes ○ No

List any additional conditions not already included

Orthopedic Injuries & Surgeries							
	YES	NO	DATE OF SURGERY		YES	NO	DATE OF SURGERY
Ankle injury/surgery				Neck injury/surgery			
Back injury/surgery				Shoulder injury/surgery			
Elbow injury/surgery				Arthritis			
Knee injury/surgery				Weakness			
Hip injury/surgery							

Please list all medications you are currently taking. If you need additional space, please inform front desk.

Medication	Dosage	Frequency	Delivery	Reason

Patient/Guardian Signature _____ Date _____

Therapist Signature _____ Date _____