ADVANCE MOVEMENT PHYSICAL THERAPY: PATIENT HEALTH HISTORY FORM

NAME ______________________________ BODY PART ___________________ DATE___________________

Date of Birth:__________________ Occupation: __________________ _________________________

Who referred you to PT? ______________ Reason for your visit:____

When did your condition start? (Date of injury/ Surgery/ Onset of pain): _______________________________________

Are you currently receiving ANY form of Home Health Care?: **YES NO** Date ended: _____________________________

Have you had previous physical therapy for this condition?/Where?: ____

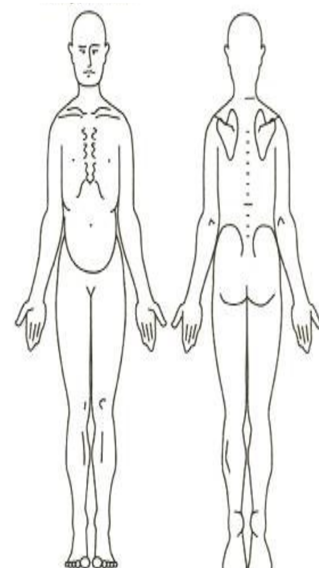
Physician: _____________________________________ Next scheduled Dr. appointment (s) Date: _________________

Have you had any of the following tests? **YES NO ___ XRAY ___MRI ___ CT Scan ___ EMG ___OTHER:__________**

Are you currently taking any blood thinners? **YES NO** If Yes, please list the date and result of your last INR test: ___________________

Are you currently taking any medications? **YES NO** Please list:____
(use back of page if you need more space)

Do you have PAIN? If so DRAW on the BODY CHART where your pain is located >>>>>>>>>>>



What does your pain feel like? (check all that apply)

___SHARP ___BURNING ___ACHING ___TINGLING ___NUMBNESS ___OTHER:_________

Does pain radiate into arms or legs? **YES NO** Does pain keep you up at night? **YES NO**

Rate your PAIN at worst on a 0 to 10 scale: **0 1 2 3 4 5 6 7 8 9 10** (circle one)
(0=none, 10=severe)

What makes your pain worse?

___ LYING DOWN ___SITTING ___STANDING ___WALKING ___OTHER:______________

What makes your pain better?

___ LYING DOWN ___SITTING ___STANDING ___WALKING ___OTHER:______________

Activity Level: **___LOW ___MEDIUM ___ HIGH** Recent weight loss or gain? **YES NO**

Are you sensitive to Heat/Ice **YES NO** Are you Pregnant? **YES NO** Were you in a Motor Vehicle Accident? **YES NO**

Are you currently experiencing or have you experienced any of the following? (check what applies)

_____Heart Disease	_____ Diabetes	_____Allergies	_____ High Blood Pressure
_____Heart Attack	_____ Pacemaker	_____Headaches	_____Thyroid Problems
_____Cancer	_____Seizures	_____Hernia (any)	_____Nervous Disorders
_____Stroke	_____Dizziness	_____Kidney Problems	_____Asthma/Shortness of Breath
_____Previous Surgery	_____Metal Implants	_____Infectious Disease	

If yes to any of the above please give details and approximate dates: ____
____

Any other conditions we should be aware of? ____

All statements above are true to the best of my knowledge____

PATIENT SIGNATURE AND DATE