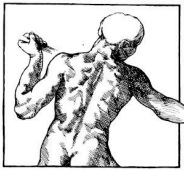


PATIENT'S HISTORY OF PRESENT INJURY



**SPINE AND SPORTS
REHABILITATION CENTER**
PHYSICAL THERAPY

Name: _____ Today's Date: _____

Age: _____ Sex: _____ Marital Status _____ No. of Children _____ Ages _____

Occupation: _____ R-handed _____ L-handed _____ Ht. _____ Wt. _____

Have you ever been a patient here before? Yes _____ No _____

If yes, for the same or different problem? Same _____ Other _____

Please indicate for which body region you are seeking treatment: Please circle.

Neck Mid Back Low Back Shoulder Elbow Hand/wrist Hip Knee Ankle/foot Other

When did your symptoms start? Date _____

Can you identify a cause for your symptoms? Yes _____ No _____

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes _____ No _____ If yes, when? _____

Have you recently had the following tests? YES / NO If **yes**, check all that apply:

- | | | |
|--------------------|----------------------|--------------------------------|
| a. x-rays _____ | e. EMG _____ | i. Stress test _____ |
| b. CT Scan _____ | f. Blood tests _____ | j. Pulmonary funct. Test _____ |
| c. MRI _____ | g. Myelogram _____ | k. Echocardiogram _____ |
| d. Bone Scan _____ | h. EKG _____ | l. Other (please list) _____ |

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
Painfree _____ Pain that would leave you unconscious

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)

Is the pain there all the time? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____ If yes, where? _____

Do you have numbness, tingling, or weakness? Yes _____ No _____ If yes, where? _____

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms?

Yes ___ No ___ Describe _____

What activities/positions make your pain worse? _____

What activities/positions make your pain better? _____

Have you seen anyone else for this problem ?

- | | | |
|-----------------------------|---------------------|------------------------------|
| a. Physician _____ | d. Osteopath _____ | g. Other (Please list) _____ |
| b. Physical therapist _____ | e. Podiatrist _____ | |
| c. Chiropractor _____ | f. Dentist _____ | |

Please circle those treatments listed below that have been tried in the past:

Physical Therapy _____ Chiropractic _____ Acupuncture _____ Braces _____ Collars _____ Tens Unit _____ Injections _____ None _____

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PATIENT'S HISTORY OF PRESENT INJURY

Other (please describe): _____

RATING SCALE: For each activity listed below, please rate appropriately by numbers using the scale below:

1-Not at all painful 2-Somewhat painful 3-Moderately painful 4-Very painful 5-Extremely painful

Activity/Function/Skill	Can do well	No/Not well	Rating	Comments/Time Tolerated
Rolling over in bed				
Transfer to/from bath				
Bathing				
Dressing				
Grooming				
Going down stairs				
Going up stairs				
Transfer to/from car				
Driving				
Sitting				
Standing				
Walking				
Lifting				
Stooping/squatting				
Carrying				
Reaching- level or				
Using telephone				
Meal preparation				
Child care				
Household cleaning				
LIST OTHER ACTIVITIES AFFECTED BY YOUR SYMPTOMS: SPORTS, HOBBIES, ETC.				

Do you take any prescription or non-prescription drugs? YES / NO If **yes** please list below:

- | | | |
|----|----|----|
| a. | d. | g. |
| b. | e. | h. |
| c. | f. | i. |

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.)

What do you want to accomplish from your course of physical therapy treatment?

PATIENT SIGNATURE

DATE

REVIEWER (PT)