Patient History

Name_____ Occupation_____

Off work due to current problem? __Yes __No If "Yes", since ___/___/___
Medications currently taking_____
Have you had COVID? _____ Are you vaccinated?_____

Medical History:	NO	YES	DETAILS, IF APPLICABLE
IMPLANTS/PROTHESIS?	___	___	_____
BLOOD THINNERS ?	___	___	_____
Arthritis	___	___	_____
Asthma	___	___	_____
Diabetes	___	___	_____
Cancer	___	___	_____
Cardiac problems	___	___	_____
Dizziness	___	___	_____
Headaches	___	___	_____
Hemophilia	___	___	_____
High Blood Pressure	___	___	_____
HIV positive	___	___	_____
Osteoporosis	___	___	_____
Pacemaker	___	___	_____
Pregnant	___	___	_____
Ulcers	___	___	_____
Other (please explain)			_____

Which is your dominant side? _____ Right ____Left: Ht. ___ft, ___inches; Wt. ___ lbs

Social History:
Do you smoke? ___Yes ___No Do you drink alcohol? ___Yes ___No

Do you feel safe at home? ___Yes ___ No

Do you exercise regularly? If so, what? _____

Describe current symptoms _____
_____

Symptoms began on _____

What caused onset of symptoms? _____
_____

Symptoms increase when I_____
_____

Symptoms decrease when I_____
_____

Have you had previous physical therapy for <u>THIS</u> condition? ___Yes ___No

List 3 important things you are unable to do because of your symptoms:
1. _____
2. _____
3. _____

Subjective pain level: 1 (least) 2 3 4 5 6 7 8 9 10 (worst)
Subjective functional level: 1 (none) 2 3 4 5 6 7 8 9 10 (full)