PERFORMANCE PHYSICAL THERAPY

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Patient Medical History:

_____ _____ _____
Patient Name Height Weight

_____ _____
Diagnosis/Injury/Condition Date of Onset/Injury

_____ _____
Type of Surgery/Procedure (If applicable) Date of Surgery

Please describe your physical limitations as a result of this injury/condition/surgery:_____

Please describe any activities/movements that aggravate your symptoms:_____

Please describe any treatments, movements, positions, or self-care that decrease your symptoms:_____

Please list any previous injuries/conditions or surgeries: _____

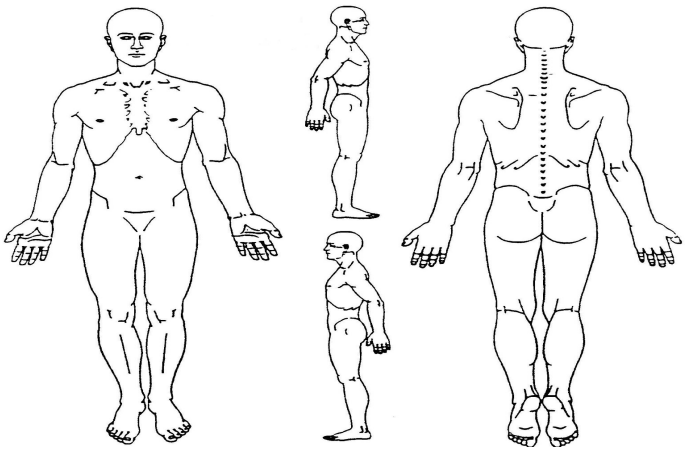
Have you had any of the following diagnostic tests in relation to this injury? (mark all that apply)
□ X-ray □ MRI □ CT Scan □ Doppler/Ultrasound
□ Other

Which of the following describes your pain?:
(mark all that apply) □ Sharp □ Dull □ Achy
□ Burning □ Tingling □ Numbness □ Other_____

Please rate your pain:(0=None, 5= Moderate,10= Severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10

Please mark all the areas of your symptom(s):



Are you currently taking ANY medications? □ Yes □ No
Please list all medications/dosages: □ Copy of detailed Medication list has been provided

_____
_____

_____ _____

Patient Name Date

Treatment History:

Have you been treated for this condition before? □ Yes □ No

If Yes by whom? (Chiropractor, PT, massage therapy, acupuncture)_____

Is this injury/condition the result of a fall? □ Yes □ No Have you fallen twice or more in the past year? □ Yes □ No

Date of falls: _____

What are your expectations/goals for Physical Therapy?_____

Any important upcoming dates (return to sport/performance/game) that you want to be ready to participate in?_____

_____

Is there anything else you would like to include or ask your physical therapist?_____

_____

Medical History: Do you now have or have you ever had any of the following? (please circle)

Allergies	Dizziness/ringing in ears/vertigo	Metal implants/pins
Anemia	Emphysema/chronic bronchitis	Multiple Sclerosis
Anxiety	Fibromyalgia/chronic fatigue	Neurological Disorder
Arthritis/swollen joints	Fractures	Numbness/tingling
Asthma	Gastrointestinal problems	Osteoporosis/Osteopenia
Bladder/Bowel problems	Headaches/Migraines	Pain syndromes/CRPS
Cancer	Heart Disease/Heart attack	Parkison's
Cardiac pacemaker/defibrillator	Hepatitis	Seizures
Circulation problems	Hernia	Stroke/TIA
Currently pregnant	High Blood Pressure	Thyroid trouble/Goiter
Depression	Incontinence	Varicose veins
Diabetes	Kidney Problems	Vision/Hearing difficulties

Please describe in detail any circled:_____

_____

Do you smoke? □ Yes □ No Daily Amount:_____ For how long?_____

Do you drink alcohol? □ Yes □ No #/day:_____ Days/Week?_____

Do you exercise regularly? □ Yes □ No How often?_____ Type/Program?_____

Do you have any hobbies/leisure activities? □ Yes □ No Type:_____

_____ _____

Patient or Guardian Signature Date