

PATIENT HISTORY FORM

*Note: This is a confidential record and will be kept in your PT chart. Information contained here will not be released to anyone without your authorization to do so.

Today's Date ____ / ____ / ____ Date of last Physician exam ____ / ____ / ____

Last Name _____ First Name _____ Middle _____

History of Present Problem

Please answer the following questions

Chief Complaint:

What is the main reason for your Physical Therapy evaluation today?

On a scale of 0-10, with 10 being the most severe, circle the number that best describes the problem?

0 1 2 3 4 5 6 7 8 9 10

**Please shade the area(s)
where the problem is.**

When did you first notice the problem?

2 days ago 2 weeks ago 1 month ago

Other _____

Does anything make the problem worse?

Moving around Standing up Lying on my side

Other _____

Does anything make the problem better?

How long does the problem last?

30 minutes 1 hour It is always there

Other _____

Is anything else occurring at the same time?

Yes No If yes, Please explain _____

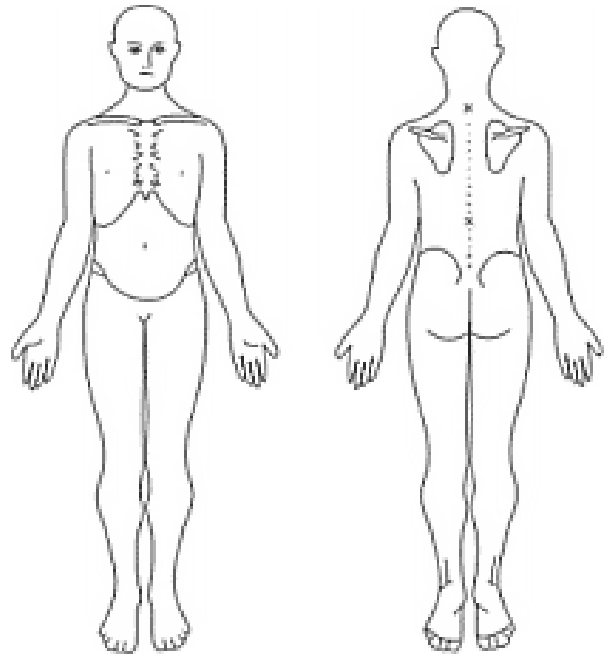
Nausea Headaches Falling

Other _____

Is the problem constant or variable?

Dull then Sharp Very sharp then leaves

Always there Other _____



Does the problem interfere with daily functions?

Yes No If yes, please explain

Past Medical & Social History

List all serious illnesses in your family. (Example: Diabetes, Tuberculosis, Breast Cancer, Heart disease, etc.)

List any personal past illnesses &/ or Surgeries and when they occurred.
Illness or Surgery Date

Are you on any prescription Medications? Yes No (If Yes, List all)

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Any over the counter medications? Yes No (If yes, please explain)

Do you smoke? Yes No

If yes, how much? _____

Do you have allergies? Yes No (If yes, please explain)

Do you drink? Yes No

If yes, how much? _____

How much caffeine do you consume daily? _____

Review of Systems

Do you now or have you had any problems related to the following systems? Circle Y or N
Please explain any yes answer.

Constitutional Symptoms

Fever	Y	N
Chills	Y	N
Headache	Y	N
Other	_____	

Integumentary

Skin Rash	Y	N
Boils	Y	N
Persistent itch	Y	N
Other	_____	

Eyes

Blurred Vision	Y	N
Double Vision	Y	N
Pain	Y	N
Other	_____	

Musculoskeletal

Joint Pain	Y	N
Neck Pain	Y	N
Back Pain	Y	N
Muscle Pain	Y	N
Other	_____	

Allergic/Immunologic

Hay Fever	Y	N
Drug Allergies	Y	N
Other	_____	

Ear/Nose/Throat/Mouth

Ear Infection	Y	N
Sore Throat	Y	N
Sinus Problems	Y	N
Other	_____	

Neurological

Tremors	Y	N
Dizzy Spells	Y	N
Numbness/tingling	Y	N
Other	_____	

Genitourinary

Urine Retention	Y	N
Painful Urination	Y	N
Urinate Frequently	Y	N
Are you Incontinent/Leaking?	Y	N
Other	_____	

Endocrine

Excessive thirst	Y	N
Too hot/cold	Y	N
Tired/Sluggish	Y	N
Diabetes	Y	N
Other	_____	

Respiratory

Wheezing	Y	N
Frequent Cough	Y	N
Shortness of Breath	Y	N
Pneumonia	Y	N
Other	_____	

