

PATIENT HISTORY

Name: _____ Sex: _____ Date of Birth: _____

1. Have you ever had? (if yes, please explain)

- | | | | |
|--------------------------------|----|-----|-------|
| High Blood Pressure | No | Yes | _____ |
| Respiratory Disorders | No | Yes | _____ |
| Heart or Circulation Disorders | No | Yes | _____ |
| Seizures | No | Yes | _____ |
| Diabetes | No | Yes | _____ |
| Cancer | No | Yes | _____ |
| Arthritis/Osteoarthritis | No | Yes | _____ |
| Osteoporosis | No | Yes | _____ |
| Immune Deficiency Disease | No | Yes | _____ |
| Other | No | Yes | _____ |

2. Please list surgeries prior injuries, or motor vehicle accidents you have had; please give procedure and dates, if possible: _____

3. Please list recent diagnostic studies (cat-scan, MRI, X-rays): _____

4. Do you have any METAL anywhere in your body; pins/plates post fracture, pacemaker?
No Yes _____

5. Do you have any abnormal trouble with vision? No Yes/ Hearing? No yes

6. List any allergies you have: _____

7. Have you ever taken steroids or anti-coagulants for extended period of time? No Yes

8. Have you had an unusual weight gain or loss lately? No Yes

9. List any medications you are now taking: _____

10. Have you ever had physical therapy treatments before? No Yes Where _____

11. Describe your symptoms and state if you have had similar symptoms in the past .

- | | |
|---|---|
| 12. How often do you experience your symptoms? | What describes the nature of your symptoms? |
| Constantly (76-100% of the day) | 1. Sharp 4. Shooting |
| Frequently (51-75% of the day) | 2. Dull ache 5. Burning |
| Occasionally (26-50% of the day) | 3. Numb 6. Tingling |
| Intermittently (0-25% of the day) | |

13. During the past 4 weeks: Average intensity of your symptoms
None 0 1 2 3 4 5 6 7 8 9 10 Unbearable

14. Date of accident, injury or start of symptoms: _____

Indicate where you have pain:

How are your symptoms changing?

1. Getting Better
2. Not Changing
3. Getting Worse

Patient Signature

Date

