

Smooth Moves PT

Patient History

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex: Male / Female Handedness: Right / Left  
Occupation \_\_\_\_\_

Are you currently off work because of this problem? Yes / No / Light duty

Diagnosis \_\_\_\_\_ Referral  
source \_\_\_\_\_

When did your problems  
begin? \_\_\_\_\_

How did your problems begin?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

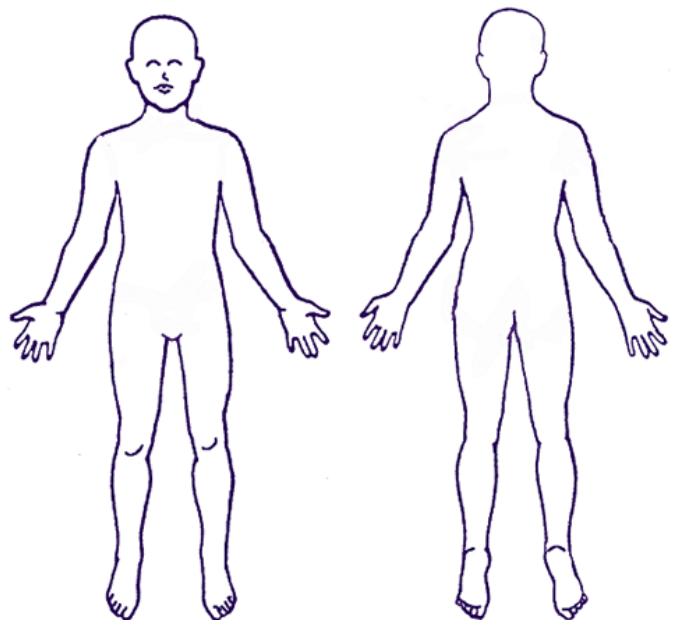
Rate your pain: no pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Draw your pain on the figure to the right  
↘

Circle the correct answers below:  
Describe your pain: dull ache sharp/stabbing  
pins&needles shooting pain burning throbbing  
twinge numbness/tingling other?  
\_\_\_\_\_

Is your pain constant? Intermittent? Fluctuates with  
activity? Wakes you at night?  
What makes your symptoms worse? Sitting  
standing walking lifting bending lying down  
squatting stress other?  
\_\_\_\_\_

Are you ever totally painfree? Yes/no  
What makes your symptoms better? Sitting



standing walking lifting bending lying down squatting stress other?

---

What time of day are your symptoms the worst? \_\_\_\_\_ the best? \_\_\_\_\_

Do you feel you are: getting better getting worse staying the same?

Have you had this problem before? Yes / No If yes, when & how did it get better?

---

---

---

Have you had any previous treatment for your current condition?

---

---

---

Have you had diagnostic studies for your current condition? (xray, MRI, CT scan  ) \_\_\_\_\_

---

---

---

Any other orthopedic problems?

---

---

---

Any medical problems?

Any surgeries?

---

---

---

---

Please list ALL medications you are currently taking, prescription and over-the-counter, for this and any other condition:

---

---

---

---

Have you ever had a history of any of the following? (please circle): major injury to head/spine cancer/tumors osteoporosis dizziness/ blackouts heart problems/angina diabetes pacemaker sudden weight loss/gain severe pain at night smoking bruising easily asthma frequent falls loss of bowel/bladder control numbness seizures/epilepsy high blood pressure coordination loss

Does your current condition limit you in carrying out job duties?

---

---

---

---

Household duties?

---

---

---

---

---

Exercise or recreation activities?

---

---

---

---

---

What are your goals in PT?

---

---

---

---

---

---

---

---

---

---

Thanks for taking the time to fill out this form as completely as possible! It will save us time during your first visit and will help in assessing your condition and guiding your treatment.