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

Describe what we are seeing you for_____

Do you have a medical diagnosis? _____Diagnosis:_____

Describe when and how your problems began? _____

_____

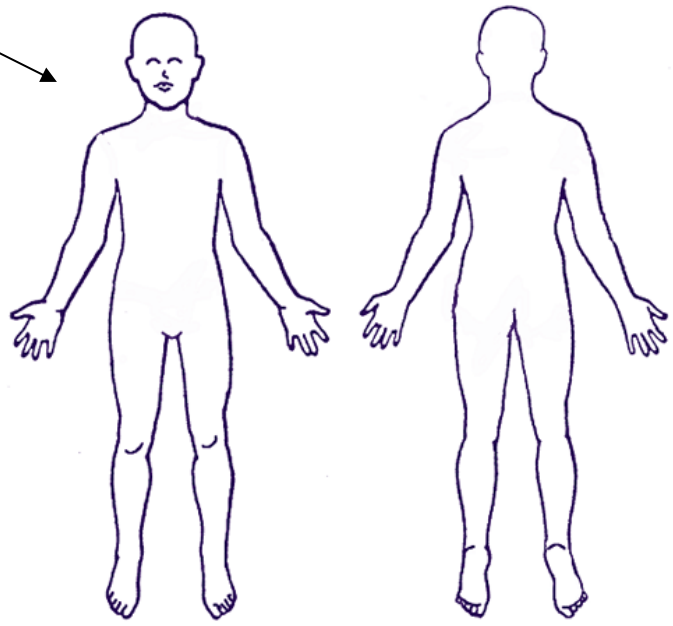
_____

_____

_____

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 use "x"s for pain, "o"s for numbness/tingling, and arrows for shooting/travelling pain



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 or intermittent? Are you ever totally painfree? Yes/no Does your pain fluctuate with activity? Wake you at night? ____x/night

What makes your symptoms worse? Sitting standing walking lifting bending lying down squatting stress other?

_____

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?

_____

_____

What diagnostic studies have you had for your current condition (ie xray, MRI, CT scan…)? And what did they show?

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

Please list things that you are limited in doing because of your current pain/injury including job duties, household duties, and 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.