PATIENT MEDICAL HISTORY INFORMATION

PATIENT NAME _____ ACCOUNT NUMBER _____ SUPPLIED BY STAFF

PROBLEM (S) REQUIRING PHYSICAL THERAPY: _____

BRIEFLY DESCRIBE THE ONSET OR CAUSE OF THE PROBLEM: _____

WAS THE CAUSE AN ACCIDENT? IF SO, CIRCLE THE APPROPRIATE? | AUTOMOBILE | | WORK |

LIST ANY PREVIOUS SIMILAR PROBLEMS: _____

HAVE YOU RECEIVED OTHER REHAB TREATMENTS THIS YEAR? | YES | | NO |

CIRCLE ANY DIAGNOSTIC TESTS DONE RELATING TO THIS CONDITION LISTED BELOW:

X-RAY	MRI	EMG	OTHER:

MEDICATIONS:	
SURGERIES:	
ALLERGIES:	
OTHER MEDICAL CONDITIONS:	

PLEASE CIRCLE HIGH & LOW PAIN LEVELS OVER THE LAST 2-3 DAYS WITH 0 = NONE 10 = EXCRUCIATING 0 1 2 3 4 5 6 7 8 9 10

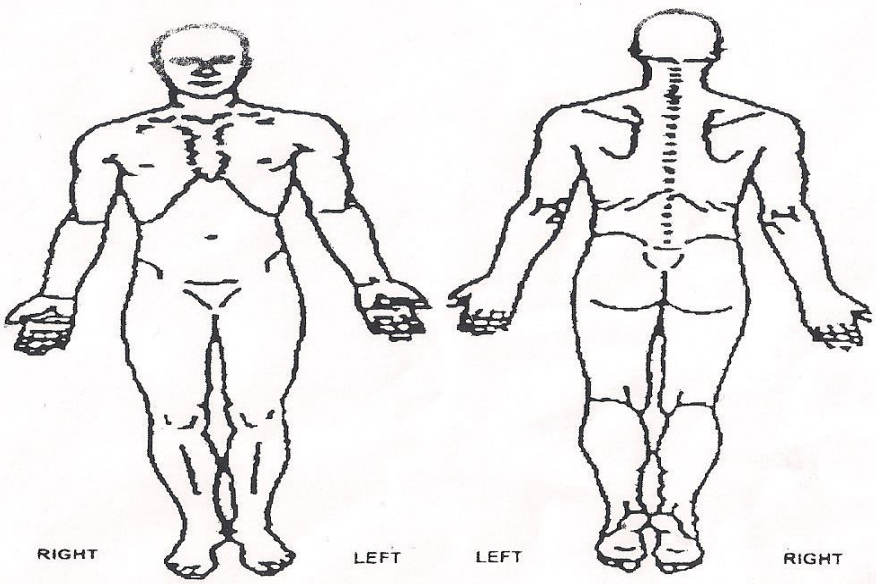
PLEASE LIST TWO OR THREE ACTIVITIES THAT GIVE YOU DIFFICULTY. ALSO RANK THE LEVEL OF DIFFICULTY FOR EACH ACTIVITY WITH 0 = NO PROBLEM AND 10 = UNABLE TO PERFORM ACTIVITY

1 _____ 0 1 2 3 4 5 6 7 8 9 10

2 _____ 0 1 2 3 4 5 6 7 8 9 10

3 _____ 0 1 2 3 4 5 6 7 8 9 10

IDENTIFY AREAS OF PAIN / SYMPTOMS ON THE DRAWINGS BELOW USING THE FOLLOWING: P = PAIN B= BURNING N= NUMBNESS S= SPASM O= OTHER



IN ADDITION TO REDUCING THE FUNCTIONAL DIFFICULTIES, PAIN AND OTHER SYMPTOMS LISTED ABOVE, PLEASE DESCRIBE ANY OTHER GOALS OR CONCERNS THAT YOU MAY HAVE.

PATIENT SIGNATURE _____ DATE _____

THERAPIST SIGNATURE _____ DATE _____