CENTRAL PHYSICAL THERAPY MEDICAL HISTORY FORM Part I

Welcome to Central Physical Therapy! **Please take your time** to complete these forms prior to your actual evaluation! Your therapist will review with you the information conduct a physical assessment and create a plan of care for you based on all the collected information. B**ring this form and any supporting documentation including recent scans or medical test results to your initial evaluation.** Contact us should you have question or require assistance in completing this form.

Patient Name: First_____ Last_____
Daytime phone: _____ Email:_____
Occupation/Duties:_____
Name of primary physician_____
Name of referring physician_____
When are you scheduled to return to your referring physician?_____
Current Team of Practitioners: Please list your current practitioners and indicate if you would like them to receive a copy of your evaluation by circling "Yes" or "No". If you circle 'Yes', please include the address the report should be sent to. *Send Copy to: Name, Profession, Address*
NO / YES_____
NO / YES_____
NO / YES_____

Current Condition:
Problem List: List current challenges that bring you to us in order of importance (i.e. My hip hurts when I walk long distances)

1. _____
2. _____
3. _____
4. _____
5. _____

- When did the problem started?_____
- Have you had similar symptoms before?_____

Goals for Therapy: List your desired outcome from a course of care in order of importance to you (i.e. I want to hike more than 1 mile without experiencing hip pain)

1. _____
2. _____
3. _____
4. _____
5. _____

Therapies/Treatments: List therapies you have tried to address the above problem(s) and if it was helpful._____
_____

Have you had any falls in the past year?	NO / YES	If so, about how many? _____
Do you have a history of fractures?	NO / YES	Where?_____
Do you have any metal implants?	NO / YES	Where?_____
Do you smoke?	NO / YES	How much per day?_____
Do you exercise regularly?	NO / YES	How often?_____
Are you pregnant or think that you might be?	NO / YES	Number of weeks_____

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Patient Name: First_____ Last_____

- Please check who have you seen for your current condition?

□ Physician/MD □ Chiropractor □ Physical Therapist □ Podiatrist
□ Physiatrist □ Neurologist □ Orthopedic Surgeon □ Dentist
□ Other (specify): _____

Past Medical History: Please list any *diagnosis, injuries/accidents, illnesses, surgeries/procedures, traumatic events*. **With each incidence please include the approximate date.**

- Have you ever had any of the following conditions? Check all that apply.

□ High blood pressure □ Heart condition □ Osteoporosis □ Stroke
□ Peripheral Neuropathy □ Seizures/epilepsy □ Diabetes □ Cancer
□ Bowel/bladder problems □ Vision problems □ Emphysema □ Asthma
□ Frequent/severe headaches □ Fainting/dizziness □ Hearing problems □ Arthritis
□ Other:_____

Medications: List any medications (prescribed, over-the-counter or supplements) that you are currently taking:

_____

_____

_____

Allergies: List any known allergies _____

_____

Surgeries/Procedures: (i.e. I had a hernia repair on the right in 1978)_____

_____

_____

_____

Injuries/Accidents: (i.e. in a car accident when I was 9 and broke my right leg)_____

_____

_____

Illnesses: (i.e. I had mononucleosis when I was 23) _____

_____

_____

_____

Other: (include anything else you feel is important)_____

_____

_____

Dental History: (include any significant dental work or problems)_____

_____

_____

Diagnostic Tests: Please check tests or procedures that had for **current** condition.

□ X-rays □ MRI □ Ultrasound □ Bone density
□ CT scan □ EMG □ Blood work □ Bone scan
□ Other:_____

Patient Signature:_____ **Date:**_____

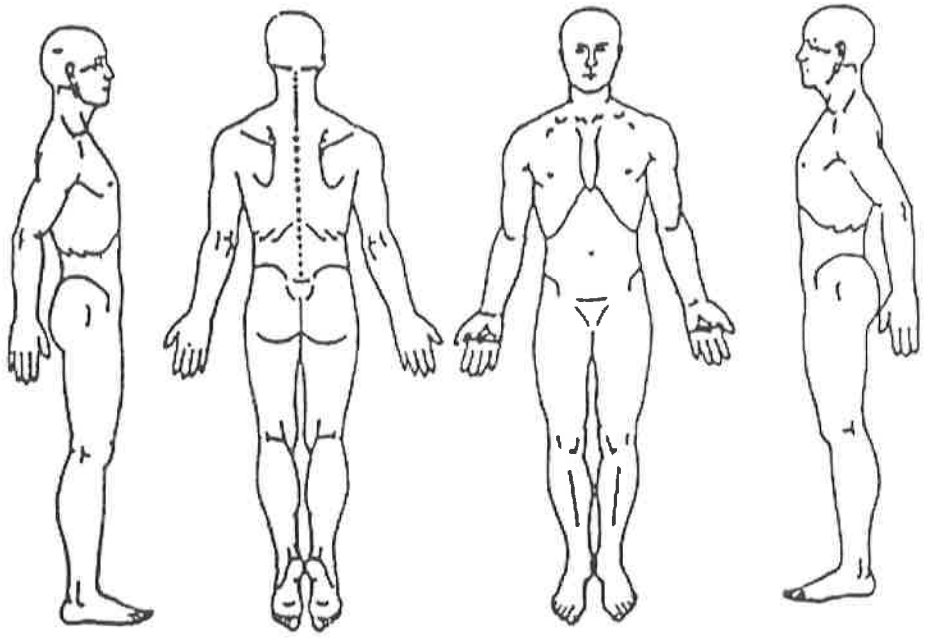
CENTRAL PHYSICAL THERAPY MEDICAL HISTORY FORM Part II

Patient Name: First_____ Last_____

Please describe the nature of your pain:

□ Sharp	□ Numbness	□ Constant (76-100%)
□ Dull	□ Shooting	□ Frequent (51-75%)
□ Aching	□ Throbbing	□ Occasional (26-50%)
□ Burning	□ Tingling	□ Intermittent (25% or less)

➔ MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



Indicate the intensity of your pain rest: **0 1 2 3 4 5 6 7 8 9 10**

Indicate the intensity of your pain with movement: **0 1 2 3 4 5 6 7 8 9 10**

What movement causes the pain to increase?_____

Since this condition began, your symptoms have: □ decreased □ not changed □ increased

Your symptoms are **WORST** in: □ morning □ afternoon □ night □ various

□ increase during the day □ same all day

Your symptoms are **BEST** in: □ morning □ afternoon □ night □ various

□ increase during the day □ same all day

Your symptoms are **WORST** during: □ lying down □ standing □ sitting

□ walking □other_____

Your symptoms are **BEST** during: □ lying down □ standing □ sitting

□ walking □other_____

Patient Signature:_____ **Date:**_____