PROACTIVE
Physical Therapy, PC

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Patient History

Today's Date _____ **Patient's Age** _____

Patient Name _____ **Patient Occupation** _____

What is the reason and/or goals you have for Physical Therapy?_____

_____

_____

Do you have pain? Yes or No

How did the pain start?

❒Suddenly ❒Pulling
❒Gradually ❒Injured at Work
❒Lifting ❒Bending
❒No apparent reason ❒Other

What activities make the pain worse?

❒Exercise(during) ❒Bending forward
❒Exercise(after) ❒Bending backward
❒Lifting ❒Coughing
❒Standing ❒Sneezing
❒Walking ❒Sitting

What reduces the pain?

❒Lying down ❒Pain Pills
❒Sitting ❒Injection for pain
❒Standing ❒Muscle Relaxants
❒Walking ❒Nothing
❒Anti-inflammatory ❒Other

How long have you had this pain?

_____Years _____Months _____Days

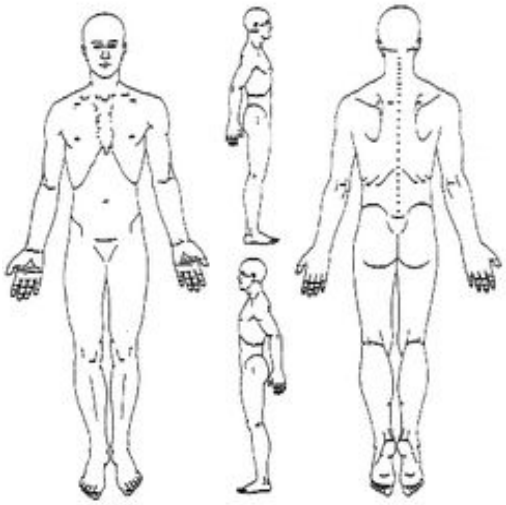
Have you had any diagnostic tests?

❒X-rays Date _____
❒CT Scan Date _____
❒EMG Date _____
❒MRI Date _____
❒Injections Date _____

Have you been hospitalized for your problem? Yes / No Date _____

Have you had surgery for your problem? Yes / No Date _____

Have you had any other surgery performed? Yes / No Date _____



On the Body Diagram to the left, indicate your region of pain using symbols below:

(X) Sharp
(+) Numb
(#) Dull/Aching
(B) Burning

_____
Pain Level (0-10)

Yes	No		Yes	No	
❒	❒	Allergies	❒	❒	Night sleep disturbances
❒	❒	Diabetes	❒	❒	Change in bowel habits
❒	❒	High Blood Pressure	❒	❒	Increased thirst or hunger
❒	❒	Stroke (CVA)	❒	❒	Frequent urination
❒	❒	Cancer or Tumors	❒	❒	Ingestion or heartburn
❒	❒	Lung Problems	❒	❒	Nausea or vomiting
❒	❒	Arthritis-joint difficulties	❒	❒	Changes in memory
❒	❒	(Ir)regular headaches	❒	❒	Unusual fatigue/weakness
❒	❒	Dizziness-blackouts	❒	❒	Frequent easy bruising Or bleeding
❒	❒	Seizure-nerve disorders	❒	❒	Frequent cramping
❒	❒	Visual Problems	❒	❒	Do you have pain 24 hrs?
❒	❒	Immunity Disorders	❒	❒	Do you awake from pain?
❒	❒	Gout	❒	❒	Do you smoke? ___#/day?
❒	❒	Are you pregnant?	❒	❒	Do you drink? ___#/day?
❒	❒	Joint replacement?			

What medications are you currently taking?

_____

What other types of doctor/healthcare providers have you seen for this problem? _____

_____

Emergency Contact (Name, Phone #, Relationship)

_____