

**INTEGRATIVE PHYSICAL THERAPY SERVICES**  
**PATIENT HISTORY**

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Sex:  Male  Female

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Area of injury or main symptoms: \_\_\_\_\_

Date your injury occurred or your symptoms started: \_\_\_\_\_

Diagnosis from your doctor: \_\_\_\_\_

Date of your next doctor recheck \_\_\_\_\_

Are you currently off work because of this problem: No Yes If yes, last day of work: \_\_\_\_\_

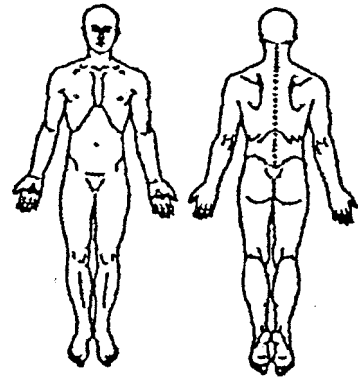
How did your symptoms start? \_\_\_\_\_

How would you describe your problem? \_\_\_\_\_

Using the diagram, circle the specific areas of pain.

Please RATE your pain levels:

No Pain 1 2 3 4 5 6 7 8 9 10 Worst Pain



Do you have any numbness or tingling? \_\_\_\_\_ Where? \_\_\_\_\_

Prior to this onset, were you free of these symptoms? Yes No Explain: \_\_\_\_\_

What eases the pain? \_\_\_\_\_

What aggravates the pain? \_\_\_\_\_

Have you had any previous treatment for this problem and did it help? \_\_\_\_\_

Do you feel you are getting better getting worse staying the same? Please circle one

Are you pregnant? Yes No Which trimester: 1 2 3

Have you had X-rays or any other special tests? Yes No Findings? \_\_\_\_\_

Please continue on back with form

GENERAL MEDICAL:

Have you or anyone in you immediate family EVER been diagnosed as having any of the following conditions?

	<u>You</u>	<u>Family</u>	<u>If family, WHO?</u>
A. Cancer: If yes, describe what kind:	Yes	Yes	_____
B. Heart Problems:	Yes	Yes	_____
C. High Blood Pressure:	Yes	Yes	_____
D. Asthma:	Yes	Yes	_____
E. Emphysema	Yes	Yes	_____
F. Chemical Dependency (e.g. drugs, alcoholism)	Yes	Yes	_____
G. Thyroid Problems:	Yes	Yes	_____
H: Diabetes	Yes	Yes	_____
I.: Multiple Sclerosis	Yes	Yes	_____
J: Rheumatoid Arthritis	Yes	Yes	_____
K. Other Arthritic Problems:	Yes	Yes	_____
L. Depression:	Yes	Yes	_____
M. Hepatitis:	Yes	Yes	_____
N. Tuberculosis:	Yes	Yes	_____
O. Stroke:	Yes	Yes	_____
P. Kidney Disease:	Yes	Yes	_____
Q. Anemia:	Yes	Yes	_____
R. Epilepsy:	Yes	Yes	_____
S. Insomnia:	Yes	Yes	_____
T. Constipation/Diarrhea:	Yes	Yes	_____
U. Other Conditions Not Listed:	Yes	Yes	_____

Have you previous had physical therapy for this problem? \_\_\_\_\_ Did it help? \_\_\_\_\_

List any daily activities or leisure activities affected by your current condition: \_\_\_\_\_

Please list any SURGERIES or any other condition for which you have been hospitalized and the date of surgery:

\_\_\_\_\_

\_\_\_\_\_

Please list all MEDICATIONS that you are currently taking for this and any other condition:

\_\_\_\_\_

\_\_\_\_\_

How many packs of cigarettes do you smoke per day? Please circle one

0      ½      ½ - 1      1 – 1 ½      1 ½ - 2      2 +