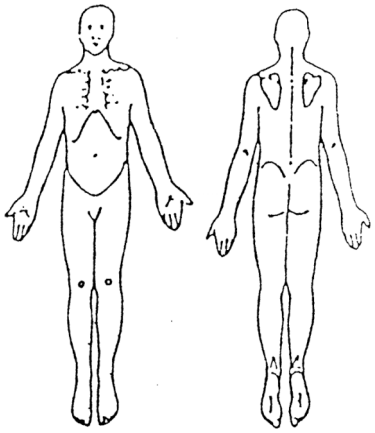
# PATIENT HISTORY FORM

**DATE**_____**NAME**_____**AGE**_____

**Why are you having Physical Therapy? (circle ) pain surgery loss of function**

**When did your symptoms start?**_____ **(mark problem area below)**



**What are your symptoms? (circle) pain numbness tingling burning weakness other (please explain)**_____

**Have you had these symptoms before?**_____**When?**_____

**Please check any activities that you have difficulty with, or are unable to perform due to your symptoms: ___ walking ___ sitting ___ standing ___ sleeping ___ squatting ___ lifting ___ carrying ___ working ___ reaching overhead ___ reaching behind back ___ pushing ___ pulling ___ going up/down steps ___ getting in/out of chair ___ driving ___ other (please explain)** _____

**Rate your pain level: least – 0 1 2 3 4 5 6 7 8 9 10 – greatest**

**Restrictions of Activities of Daily Living/Functional Index (No Limitations) 0 1 2 3 4 5 6 7 8 9 10 (Totally disabled)**

**Have you had any of the following tests or treatments for your current symptoms? (circle) Xray CT scan MRI Epidural injection Physical Therapy**

**If you were hospitalized for your current symptoms, list dates**_____

**Are you receiving Home Health services in your home?**_____

**Please list current prescription medication you are taking**_____

**Have you been treated for any of the following conditions? (circle) Cancer Cardiac conditions Diabetes Do you have a Pacemaker?**_____**Are you Pregnant?**_____

**Other Past Medical History**_____

**Are you currently working?**_____**Occupation**_____**How long have you been doing this job?**_____

**Employer**_____

**If you are age 65 or older and a Medicare recipient, please answer the following questions: Have you had any falls in the past 12 months?_YES/NO____How many falls**_____
**Were you injured in any falls?**_____

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**(FOR OFFICE USE ONLY)** ☐**10/30**
**DX:**