

Patient History

Patient Name _____ DOB _____

What is the current problem for which you were referred? _____

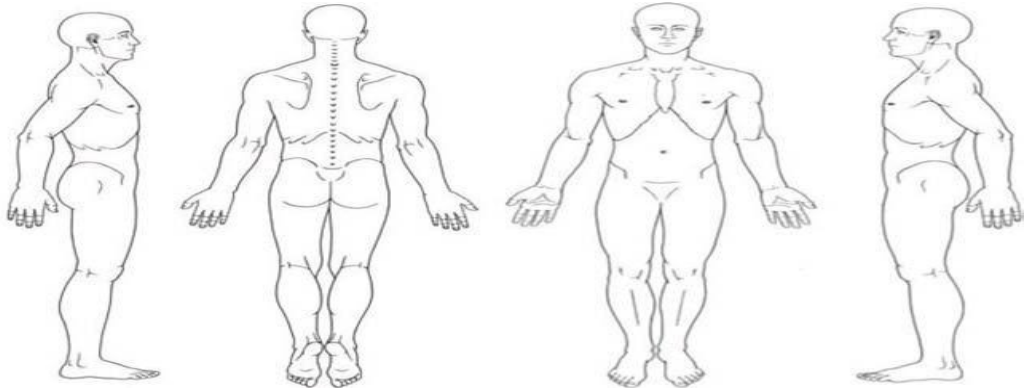
What is your current occupation? _____

Date of next doctor appointment: _____ When did your symptoms start? _____

How did your symptoms begin? _____

Please indicate on the body views, where you have pain and or other symptoms:

Please mark on body diagram with
 /// or xxx where each symptom is
 located: Pain ///
 Pins & Needles xxx



Please rate your pain in this scale
 of 0-10.

0 1 2 3 4 5 6 7 8 9 10
 no pain worst pain imaginable

Please list all medications you are presently taking. _____

Please complete the following information regarding any special tests you have had done for this condition.

MRI X-ray CAT Scan other _____ Date completed _____

Have you had any of the following this year?

Physical Therapy ___ Occupational Therapy ___ Speech Therapy ___ Chiropractic care ___ Home care ___

If yes, where were you treated and for what condition?

Allergies (medications, environmental, tape, lotions, latex, food, other) _____

Past or Present Medical History

- | | | |
|---------------------------------|---|------------------------------|
| ___ Cancer/Type _____ | ___ Headaches | ___ Vision/Hearing Problems |
| ___ Metal Implants | ___ Diabetes | ___ History of HIV/Hepatitis |
| ___ Fractures | ___ Open Wounds | ___ Pacemaker |
| ___ High Blood Pressure | ___ Cardiac Problems (describe below) _____ | ___ Skin Problems |
| ___ Are you currently pregnant? | ___ Drink/how often _____ | ___ Asthma |
| ___ Smoke/how often _____ | ___ Stroke/When _____ | ___ Mental Illness |
| ___ Arthritis | | |

Other medical conditions or surgeries _____

What goals do you hope to accomplish with your physical/occupational therapy? _____

Patient's signature _____ Therapist's signature _____

Date _____

Date _____