U DISTRICT PT
PHYSICAL THERAPY

PATIENT HISTORY

Date: _____

Name : (Last) _____ (First) _____ (MI) _____

Gender: _____ Male _____ Female DOB: _____ Age: _____

Please describe your condition or symptoms: _____

_____

OCCUPATION: _____

Have you missed any work or school due to your condition? _____ Yes _____ No

Date your condition/symptoms began? _____

Name of referring physician: Dr. _____

Did you have surgery? _____ Yes _____ No

If yes, what procedure was performed? _____ on (date) _____

Please rate your pain level: No Pain 0 1 2 3 4 5 6 7 8 9 10 Severe Pain

Location of pain: _____ Right _____ Left _____ N/A

How would you describe your pain?

_____ burning	_____ numbness	_____ tingling
_____ sharp	_____ throbbing	_____ constant
_____ dull/achy	_____ shooting	_____ intermittent
_____ worse in AM	_____ worse in PM	_____ other

Prior to onset, were you free of these symptoms? _____ Yes _____ No

What eases symptoms? _____

What aggravates symptoms? _____

Have you had treatment for this condition? _____ Yes _____ No

What type of treatment and where? _____

Did this treatment help? _____ Yes _____ No

Have you had any X-Rays, MRIs, or other diagnostic procedures ? _____ Yes _____ No

What were the findings from imaging/facility imagining was taken? _____

PATIENT HISTORY

GENERAL MEDICAL INFORMATION

Mark **Y** or **N** if you currently or have ever had any of the following conditions:

_____	Osteoarthritis		_____	High Blood Pressure		_____	Hepatitis	
_____	Diabetes	_____	_____	Hyperglycemia		_____	Huntington's	
_____	Allergies	_____	_____	Hypoglycemia		_____	Fibromyalgia	
_____	Cancer	_____	_____	Anemia		_____	Current Infection	
_____	Arthritis	_____	_____	Cerebral Vascular Accident		_____	Lupus	
_____	Thyroid Problems		_____	Cauda Equina Syndrome		_____	Epilepsy	
_____	Immunosuppression		_____	Eating Disorder		_____	Depression	
_____	Mental Health Disorder		_____	Cardiovascular Disease		_____	Obesity	
_____	Alzheimer's		_____	Bowel/Bladder Changes		_____	Parkinson's	
_____	Traumatic Brain Injury		_____	Muscular Dystrophy		_____	Asthma	

Tobacco Use	Yes	No	Pregnant/Nursing	Yes	No
Alcohol Use	Yes	No	Pacemaker	Yes	No
Marijuana Use	Yes	No			

Please list any surgeries or injuries (fractures, dislocations, sprains etc) **associated with your currently injury** for which you have been treated or hospitalized including approximate dates:

_____

_____

Please list or attach all prescription and over the counter medications you are currently taking
MEDICARE PATIENTS MUST LIST OR ATTACH MEDICATIONS AND DOSAGES

_____

_____

What are the most important things you hope to accomplish with physical therapy?

_____

_____

Patient Signature: _____ Date: _____