IMPACT PHYSICAL THERAPY

PATIENT HISTORY

Name_____Male____Female____Date_____
Age_____Height_____Weight_____Occupation_____

CHIEF COMPLAINT AND PRESENT ILLNESS:

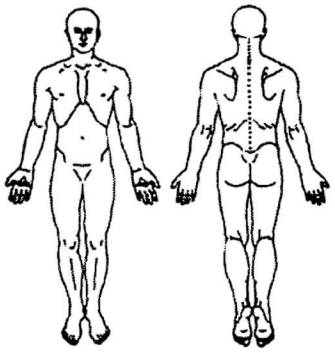
Area of injury/symptoms_____Date your symptoms/injury started_____

How did your symptoms start?_____

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 worked

Using the diagram, circle the specific area of pain. If pain travels, draw arrows.



Please RATE your pain level. No pain 1 2 3 4 5 6 7 8 9 10 Worst pain.

How would you DESCRIBE your pain?

dull ache_____ burning_____ heavy_____ sore
deep ache_____ throbbing_____ twinge_____ other
stabbing_____ squeezing_____ cramp
nagging_____ drawing_____ sharp

Are your symptoms intermittent or constant? (circle one)

Do you have any numbness/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 other treatment for this problem?_____ What? Chiropractic ___ Physical Therapy___ Other ___

Did it help?

Do you feel you are getting better, getting worse or staying the same? (circle one)

Have you had x-rays? yes_____ no_____ Findings?

Have you had an MRI? yes _____ no _____ Findings?

Please list any other tests you have received:

Women only: Are you pregnant? yes_____ no_____ Which trimester? 1_____ 2_____ 3

Any other concerns or health changes since the start of this injury/illness?

ACTIVITIES OF DAILY LIVING: Circle activities that are difficult for you and then check the appropriate box.

	no difficulty	with difficulty/pain	cannot perform
Personal hygiene: hair, bathing, toilet			
Dressing: zippers/buttons, upper body, lower body, shoes			
Household chores: reach overhead, lifting/carrying, dust vacuuming, mopping, Meal Preparation: use stove, do dishes			
Yard/Garden: mowing, tilling, weeding, raking, watering			
Walking: stairs, curbs, incline, decline, uneven ground, distances Transportation: Drive self, ride with others, bus, taxi, shopping			

LIST YOUR LEISURE ACTIVITIES (circle those affected by your current problem):

_____

GENERAL MEDICAL:
Have you EVER been diagnosed as having any of the following conditions?:

A. Cancer	YES	K. Other arthritic problems	YES
If YES, describe what kind: _____		L. Depression	YES
B. Heart problems	YES	M. Hepatitis	YES
C. High blood pressure	YES	N. Tuberculosis	YES
D. Asthma	YES	O. Stroke	YES
E. Emphysema	YES	P. Kidney disease	YES
F. Chemical dependency (i.e. alcoholism)	YES	Q. Anemia	YES
G. Thyroid problems	YES	R. Epilepsy	YES
H. Diabetes	YES	S. Insomnia	YES
I. Multiple Sclerosis	YES	T. Constipation/diarrhea	YES
J. Rheumatoid arthritis	YES	U. Other: _____	

If you have been seen by any health care provider during the past 3 months for reasons other than what brought you here, please describe for what reason:

Please list any SURGERIES you have had or any INJURIES for which you have have been treated (please include approximate dates):

Please list ALL PRESCRIPTION and/or OVER-THE-COUNTER medications you are currently taking for this and any other condition (including pills, injections, and/or skin patches):

GOALS: Please list your personal goals for therapy:

_____ _____

Patient/Parent/Guardian Signature **Therapist Signature**