PATIENT HISTORY

Country Roads
PHYSICAL THERAPY

Date: _____

Name: _____ ☐Male ☐Female SSN: _____

Address: _____ Home phone: _____ Cell phone: _____

Name of Primary Care Physician: _____ Phone: _____ Insurance: _____

Name of Referring Physician: _____ How did you hear about us? _____

Emergency Contact Name: _____ Relationship: _____ Number: _____

Leisure activities, including exercise routines: _____

Are you currently working with a personal trainer? ☐Yes ☐No

Occupation, including activities that comprise your workday: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

Are you on a work restriction from your doctor? ☐Yes ☐No Are you latex sensitive? ☐Yes ☐No

Do you smoke? ☐Yes ☐No Do you have a pacemaker? ☐Yes ☐No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐Yes ☐No
If yes, please discuss with your therapist.

ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following? Check all that apply:

- ☐ fatigue
- ☐ fever / chills / sweats
- ☐ nausea / vomitting
- ☐ weight loss / gain
- ☐ difficulty mainting balance
- ☐ falls
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ dizziness / lightheadedness
- ☐ heartburn / indigestion
- ☐ difficulty swallowing
- ☐ changes in bowel or bladder function
- ☐ constipation
- ☐ diarrhea
- ☐ shortness of breath
- ☐ fainting
- ☐ cough
- ☐ headaches

Have you EVER been diagnosed with any of the following conditions? Check all that apply:

- ☐ cancer
- ☐ heart problems
- ☐ chest pain / angina
- ☐ high blood pressure
- ☐ circulation problems
- ☐ blood clots
- ☐ stroke
- ☐ anemia
- ☐ bone or joint infection
- ☐ chemical dependency
- ☐ depression
- ☐ lung problems
- ☐ tuberculosis
- ☐ asthma
- ☐ rheumatoid arthritis
- ☐ other arthritic condition
- ☐ bladder / urinary tract infection
- ☐ kidney problem / infection
- ☐ sexually transmitted disease / HIV
- ☐ pelvic inflammatory disease
- ☐ thyroid problems
- ☐ diabetes
- ☐ osteoporosis
- ☐ multiple sclerosis
- ☐ epilepsy
- ☐ eye problem / infection
- ☐ ulcers
- ☐ liver problems
- ☐ hepatitis
- ☐ pneumonia

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Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? Check all that apply:

- ☐ cancer
- ☐ heart problems
- ☐ high blood pressure
- ☐ diabetes
- ☐ stroke
- ☐ depression
- ☐ tuberculosis
- ☐ thyroid problems
- ☐ blood clots

Please list any medications you are currently taking (including pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? ☐ Yes ☐ No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

Check which apply to your symptoms:

- ☐ work-related injury
- ☐ injury related to lifting
- ☐ athletic / recreational injury
- ☐ recurrence of previous injury
- ☐ injury related to falling
- ☐ motor vehicle accident
- ☐ other
- ☐ causes unknown

If cause is known, please explain: _____

What is your chief complaint? _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

I should not do physical activities that might make my pain worse: ☐ Disagree ☐ Unsure ☐ Agree

Treatment received so far for this problem (chiropractic, injections, etc)_____

Please list special tests performed for this problem (x-ray, MRI, labs, etc)_____

Have you ever had this problem before? ☐ Yes ☐ No When _____ Treament received _____

How long did it take for you to feel better? _____

PATIENT HISTORY

RATE YOUR PAIN LEVEL

Using the 0-10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable," please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

CHECK YOUR SYMPTOMS

Please indicate where your symptoms are located: