onthemend
PHYSICAL THERAPY

PATIENT HEALTH SUMMARY

Name:_____ Age:_____ M F DOB:_____

Occupation/Student (grade):_____ Hand Dominance: R / L *(circle one)*

Reason you are being seen today:_____

Have you had any diagnostic testing for your current condition? If so, what tests:_____

Date of injury or when your symptoms began:_____

How were you injured?_____

Describe your current symptoms:_____

What makes your symptoms worse?_____

What makes you feel better?_____

How long can you stand?_____ sit?_____ walk?_____

Have you experienced afall within the past 12 months? [ ] Yes [ ] No If so, were you injured? [ ] Yes [ ] No

Do you have a previous history of the condition for which you are being seen today? Yes_____ No_____

What leisure/physical activities do you enjoy?_____

What activities/movements can you no longer do due to your injury?_____

What are your goals for therapy?_____

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes_____ No_____

Medication/Injection and condition taken/given for: _____

_____

Please check all that apply to you:

___ Cancer	___ Emphysema	___ Infectious Disease	___ Prostate Condition
___ Heart Condition	___ Hepatitis/kidney problems	___ Diabetes	___ Bowel/bladder
___ High BP/hypertension	___ Tuberculosis	___ Glaucoma	___ Emotional Problems
___ Pacemaker	___ Phlebitis/Circulatory Problems	___ Thyroid Problems	___ Migraines/headaches
___ Asthma	___ Stroke	___ Arthritis	___ Dizzy Spells
___ Lung Disease	___ Anemia	___ Multiple Sclerosis	___ Seizure
		___ Neurological Disorder	___ Tobacco use

Are you currently pregnant? Yes_____ No_____

Is there anything else you feel we should be aware of? (fractures, other medical conditions)

_____

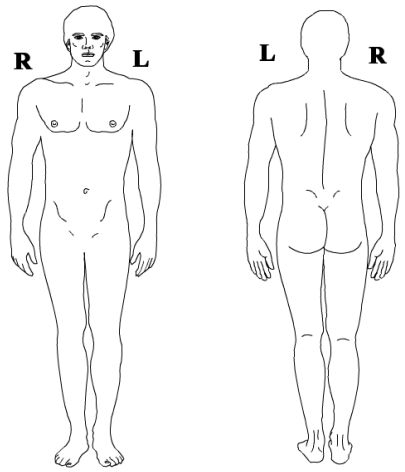
List surgeries you've had: _____

Circle the number that best describes your status:

PAIN 0 1 2 3 4 5 6 7 8 9 10

Best _____Worst

Please shade in the areas where you are experiencing pain:



Please notify your therapist if there are any changes in your condition.
Thank you for coming to our clinic for your therapy needs.

Patient Signature Date