PATIENT HEALTH HISTORY

Name: ____ **Date of Birth**: __________________________

HISTORY OF PRESENT CONDITION

Current Complaints: ____

When did your symptoms start (date)? ____

If you are coming in due to an injury, how did you injure yourself? ________________________________

If you are coming in after surgery please explain: ____

Surgery Date: ____

List diagnostic tests for this problem (x-rays, MRI, EMG, etc):

______ *check if no previous diagnostic testing*

TEST	DATE	RESULT

PAIN

Please describe your pain (e.g. burning, stabbing, ache): ____

Where is your pain located? ____

When is the pain at its worst? _____Morning _____Night _____With Activity _____At rest

Is the pain? _______Constant _______On and Off

Please fill in the appropriate number for each of the below times:

Rating -> 0----------------------5--------------------10

Now? ______ At its best? ______ At its worst? ______

____No Pain ____Moderate ____Hospital

Are your symptoms getting….? ________Better ________Worse ________Staying the same

What makes your symptoms worse? ____

What makes your symptoms better? ____

What activities do you have difficulty doing? ____

What previous activities do you want to resume? ____

Are you out of work because of this problem? _____ Yes _____No

When do you intend to return to work (date)? ____

What treatment have you received for this present condition (surgery, injections, chiropractor, splint, or brace, medication, etc.)? ____

____

Are you planning to follow-up with the referring physician? _____Yes _____No

If so, when? ________________

PAST MEDICAL HISTORY

Please check if you have any of the following:

____Allergies ____COPD ____High Blood Pressure ____Multiple Sclerosis

____Visual Loss ____Anemia ____CVA (Stroke) ____HIV/AIDS

____Parkinson's ____Other ____Arthritis ____Diabetes

____Hypoglycemia ____Polio ____Bone Loss ____GOUT

____Kidney Disease ____Seizure Disorder ____Cancer ____Hearing Loss

____Liver Disease ____Thyroid

____Cardiac *(MI, Arrhythmia, Angina)* ____Lupus ____Vascular Disease

Other: *(explain)* ____

____

____

PAST SURGERIES

TYPE	DATE
1.	
2.	
3.	
4.	

Have you ever broken any bones? ________________________________

Past motor vehicle accidents? ________________________________

Please note any known allergies to medications:____________________________

Do you wear a pacemaker? ________________________________

Do you have any metal implants? ________________________________

Are you or do you think you may be pregnant? ______ Yes ______No

Do you smoke? ____Yes ____No How long have you smoked? ____________________

Occupation: ________________________________

Are you working? ____Full ____Part-Time ____Retired _____Student ____Not Employed

TheraMAX
Rehabilitation & Sports Physical Therapy

BODY DIAGRAM

INSTRUCTIONS

On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present condition.

Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.

| -- |

No Pain *Worst Pain Possible*

Shade in the areas on the diagram that correspond to your pain or symptoms *(circle all that apply)*

Sharp **Dull** **Aching** **Burning Tightness**

Numbness **Tingling** **Localized Radiating** **Constant Intermittent**

Patient Signature: ________________________ **Date:** ____________