PATIENT HISTORY FORM

DATE _____ **NAME** _____ **AGE** _____

Why are you having Physical Therapy? _____

When did symptom onset/injury occur? _____

What are your symptoms? ○ Pain ○ Numbness ○ Tingling ○ Burning ○ Weakness

Other symptoms (please explain) _____

Have you had any of the following tests or treatments for your current symptoms? ○ X-ray ○ MRI ○ Injection ○ Physical Therapy

If you were hospitalized for your current symptoms, list dates:

_____

Are you receiving home medical services in your home? _____

Past Orthopedic Surgeries (bones/joints/tendons/ligaments):

_____

Return date to doctor (if known)? _____

Are you currently working? _____

Occupation: _____

How long have you been doing this job? _____

Employer: _____

HEALTH HISTORY

Cardiovascular (heart) Risk Factors (check all that apply):

☐ Obesity ☐ Pre-diabetes ☐ Family History of heart disease

☐ High blood pressure ☐ High cholesterol ☐ Pacemaker

Have you been previously diagnosed with the following (check all that apply):

☐ Cardiovascular Disease (CVD), Peripheral Artery Disease (PAD), Coronary Artery Disease (CAD)

☐ Pulmonary Disease (COPD/Asthma/Interstitial Lung Disease)

☐ Diabetes (Type 1 or Type 2?)

☐ Other Metabolic Disorders (Thyroid disorders, renal, liver disease)

☐ Cancer, and, if so, what type

☐ Depression/Anxiety/other

Over the last 3 months please rate:

1. Your overall health 0-10 (10 being best):
2. The healthiness of your diet 0-10 (10 being best):
3. Your average daily stress level 0-10 (10 being highest stress):
4. Your current physical activity level 0-10 (10 being highest activity):
5. How many servings of fruit and vegetables do you consume on an average day?
6. On average, how many hours of sleep do you get each night?
7. Do you use tobacco, if so, what form and for how long?
8. If you consume alcohol, what is the average number of drinks at a time?