PATIENT BACKGROUND INFORMATION

Name: ____ **Date:** _____________________
Referring Physician: ____

Past Medical History: Please check if you have (or have had) any of the following:

___Heart Problems ___ Rheumatoid Arthritis ___ Emphysema
___ High Blood Pressure ___ Osteoarthritis ___ Asthma
___ Diabetes ___ HIV/AIDS ___ Cancer
___ Seizures ___Stomach Problems/Ulcers ___ Other: ______________

Medications: Please list any medications that you take regularly, and the physician who prescribed them: ____
____
____

Allergies: Please list any allergies that you have and describe your reaction: _______________
____

Current Medical History:
What is the primary reason for your visit today? _____________________________________
When did the injury/condition first occur? ____
Please describe how the injury/condition occurred: ___________________________________
____
What makes symptoms worse? ____
What relieves your symptoms? ____
If you have pain, make an "X" on the scale below to indicate how much you have at rest/low activity, and then make an "O" on the scale to indicate how much you have during an episode/high activity:

____

No Pain **Worst Pain Ever**

What is your occupation? ____
Please describe a few things which you are unable to do since this injury/condition occurred which you normally can do? ____
Please describe any other concerns or information which you would like to discuss with you physical therapist? ____
____
____