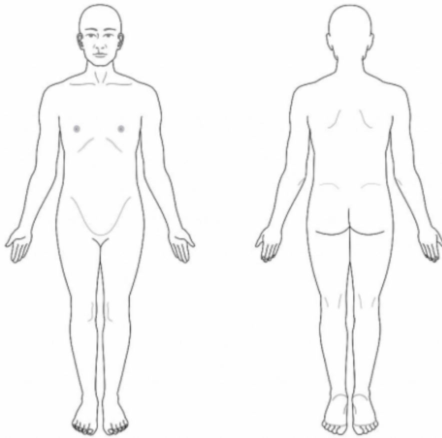
COMPLETE PHYSICAL THERAPY

PATIENT HISTORY FORM

Patient Name: ______________________________ **DOB:** ______________ **Today's Date:** ______________

What are you seeing us for? ______________________
____
____

Please indicate where you have pain/symptoms:



When did this issue begin? ______________________

Describe the history of this problem (i.e. how did it occur?): ________________________________
____
____

Was the onset of your symptoms gradual or sudden?
gradual sudden

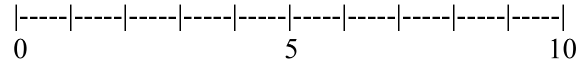
Have you had similar symptoms in the past?
Yes No

Overall, are your symptoms:
improving getting worse no change

How would you describe your symptoms? (select all that apply)

sharp	dull
numbness	tingling
throbbing	shooting
aching	burning
other:	

Please indicate the average intensity of your symptoms: (0-lowest, 10-highest)



0 5 10

As you go through your day, do your symptoms:
increase decrease stay the same

Does pain ever wake you up at night?
Yes No

What aggravates your symptoms?

sitting	lying down
walking/running	up/down stairs
reaching overhead	lifting objects
playing a sport	repetitive activities
standing	bending forward
sleeping	coughing/sneezing
turning/twisting body	sustained movements
stress	other ____________

Does anything relieve your symptoms? Please explain:
____
____
____

Have you had any previous treatment or tests for this condition? (select all that apply)

physical therapy	massage therapy
chiropractic care	traction
bracing/taping	hospitalization
bed rest	exercise
home health care	x-ray
MRI	CT scan
EMG	bone scan
acupuncture	casting
medication/injection	other ____________

Please list any current medications, including over the counter and supplements: ______________________
____
____
____

7304 Lakewood Dr. W, Suite 23 Lakewood, WA 98499
Phone 253. 314.5762 Fax 253.314.5951

PATIENT HISTORY FORM

Patient Name: ____ **DOB:** ______________ **Today's Date:** ______________

Since your symptoms began, have you had any of the following?

- bowel or bladder issues
- weakness
- dizziness or fainting
- fever/chills/sweats
- significant weight change
- hearing or vision problems
- numbness or tingling
- difficulty swallowing
- pain at night
- numbness in the anal or genital area
- vague feeling of bodily discomfort
- NONE

Are you currently able to perform all of your regular work/home duties? Yes No

If no, please list activities that you are not able to do:
____
____

In general, would you say your overall health is:

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

Poor Excellent

Your overall exercise/activity level is:

|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|

Inactive Very Active

If active, please describe: __________________________
____

Do you smoke? Yes No
_____ packs/day _____ packs/week

Do you drink alcohol? Yes No
_____ drinks/day _____ drinks/week

Occupation: ___________________________________

Does your job include any of the following?
sitting standing lifting

What is your current living situation? (select all that apply)

- live alone
- live with family/friends
- have caregiver
- retirement community
- home/apartment
- single level/no stairs
- assisted living
- multiple levels/stairs
- other: ___________

Do you currently have or have you had a history of any of the following? (select all that apply)

Diabetes	High blood pressure
Cancer/Tumor	IBD (Crohn's,UC)
Anemia	Stroke
Osteoporosis	Nausea/Vomiting
Cardiac-arrhythmias	Pacemaker
Blood clots	Peripheral Vascular Disease
Bruising easily	Neurological conditions
Sleep disorder	Seizures/Epilepsy
Thyroid problems	Pulmonary conditions
Multiple Sclerosis	Kidney problems
Parkinson's disease	Fractures
Joint replacement	Arthritis/Swollen joints
Rheumatoid arthritis	Fibromyalgia
Osteoarthritis	Gout
Headaches/Migraines	Dizziness/Vertigo
Loss of balance/Falls	Shortness of breath
Infectious disease	Use of steroids/inhalants
Currently pregnant	Depression
Chemical dependency	Sensitivity to heat/ice
Angina	Coronary Artery Disease
Allergy to adhesive/ tape/lotions	Other: _________________

Please list any PREVIOUS surgeries:

1.________________________________Date:_________
2.________________________________Date:_________
3.________________________________Date:_________
4.________________________________Date:_________
5.________________________________Date:_________

7304 Lakewood Dr. W, Suite 23 Lakewood, WA 98499
Phone 253. 314.5762 Fax 253.314.5951