Patient History Form

New Motion Physical Therapy Inc., PS

Name: _____ **Age** _____ **Today's Date:** _____

Height _____ **Weight** _____

Do you smoke? Yes No **Do you have a pacemaker? Yes No** **Are you pregnant? Yes No**

Do you have any allergies? Please list
Latex? Yes No
_____
_____
_____

Occupation:_____

Sports:_____

What is the primary problem/symptom?
_____
_____
_____
_____

Do you have additional problems/symptoms?
_____
_____
_____
_____

When did your problem begin/start ?
_____

Since the onset, has your problem gotten:
☐ **Worse** ☐ **Better** ☐ **Stayed the same**

Do you have a prior history of this problem?
☐ **Yes** ☐ **No** **When:**
_____

How long did it take you to get better?
_____

Have you had any of these diagnostic studies or treatments for your current problem? (check all that apply)

		Date:
Diagnostic X-Rays	☐	_____
MRI	☐	_____
CT scan	☐	_____
Injections	☐	_____

Other_____
_____
_____
_____

Can you sleep at night due to symptoms?
☐ **Yes** ☐ **Difficulty falling asleep** ☐ **Disturbed by pain**
☐ **Only with medication**

How do you feel upon rising?
☐ **Fine** ☐ **Stiff** ☐ **Sore** ☐ **Same**

Once you begin moving about, does the pain:
☐ **Worsen** ☐ **Ease** ☐ **Stay the Same**

What is it like at the end of the day?
☐ **Worse** ☐ **Better** ☐ **Same**

What activities decrease the pain? (check all that apply)

☐ **Lying down**	☐ **Pain Pills**
☐ **Sitting**	☐ **Aspirin**
☐ **Standing**	☐ **Anti-inflammatories**
☐ **Walking**	☐ **Heat**
☐ **Exercises**	☐ **Cold**

Other _____

What activities increase the pain? (check all that apply)

☐ **Exercise (during)**	☐ **Bending forward**
☐ **Exercise (after)**	☐ **Bending backward**
☐ **Sitting**	☐ **Coughing**
☐ **Standing**	☐ **Sneezing**
☐ **Walking**	☐ **Heat**
☐ **Running**	☐ **Cold**

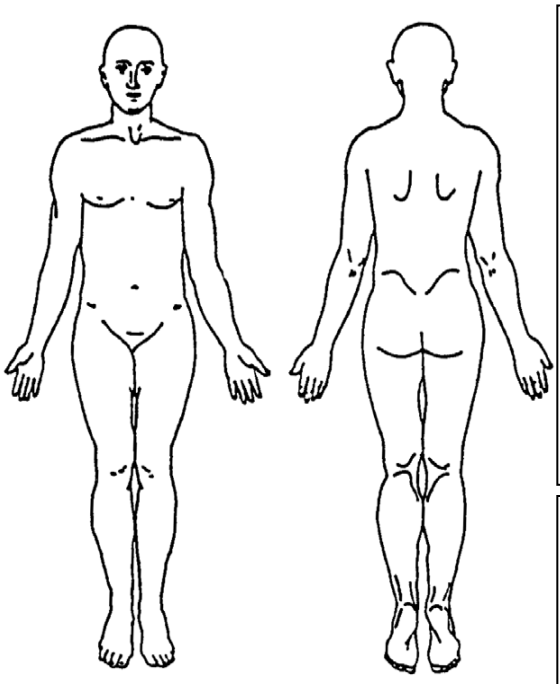
Other _____

I should not do physical activities that might make my pain worse
☐ **Disagree** ☐ **Unsure** ☐ **Agree**

Do you expect to return to the activity levels that you were at prior to developing these symptoms?
☐ **Yes** ☐ **No**

Pain Assessment

Body Chart: Please mark areas where you feel symptoms with the following descriptive symbols:



← Shooting sharp pain
0 Dull/aching pain
/// Numbness
= Tingling

My symptoms currently:

☐ Come and go

☐ Are constant

☐ Change with activity

On a scale of 1 – 10 rate your pain at:

Rest____ Pain in last 24 hrs _____

Rate your worst pain _____

What is the quality of the pain – check all that apply:

Sharp	☐	Throbbing	☐
Cramp	☐	Burning	☐
Dull	☐	Shooting	☐
Achy	☐	Other_____	

Faces of Pain Scale: Please circle your current level of pain

Balance Screening

Have you had two or more falls in the last 12 months?	**YES**	**NO**
Are you here today for physical therapy because of a fall?	**YES**	**NO**
Are you having difficulty with walking or balance?	**YES**	**NO**

Please list all current Medications:

_____

_____

_____

_____

_____

Have you been hospitalized or had surgery? Please list with dates.

1._____ 2._____ 3._____

4._____5._____6_____

Have you recently noted any of the following (Check all that apply)?

- ☐ **Fatigue**
- ☐ **Fever/chills/sweats**
- ☐ **Nausea**
- ☐ **Weight loss/gain**
- ☐ **Difficulty with balance**
- ☐ **Muscle weakness**

- ☐ **Falls**
- ☐ **Numbness or tingling**
- ☐ **Dizziness/ light headedness**
- ☐ **Difficulty swallowing**
- ☐ **Changes in bowel or bladder**
- ☐ **Constipation**

- ☐ **Diarrhea**
- ☐ **Shortness of breath**
- ☐ **Fainting**
- ☐ **Cough**
- ☐ **Headaches**

Have you ever been diagnosed with any of the following conditions (check all that apply)?

- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ High blood pressure
- ☐ Circulation problems
- ☐ Blood Clots
- ☐ Stroke
- ☐ anemia
- ☐ Bone or join infection
- ☐ Chemical dependency
- ☐ Depression
- ☐ Lung problems

- ☐ Tuberculosis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Rheumatoid Arthritis
- ☐ Other arthritic conditions
- ☐ Bladder/Urinary tract infection
- ☐ Kidney problem/infection
- ☐ Sexually transmitted disease
- ☐ Pelvic inflammatory disease
- ☐ Thyroid problems
- ☐ Diabetes

- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Eye problems/infection
- ☐ Ulcers
- ☐ Liver problems
- ☐ Hepatitis
- ☐ Immunosuppression
- ☐ Fracture or suspicion of fracture

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)

- ☐ Cancer
- ☐ Heart problems
- ☐ High blood pressure

- ☐ Diabetes
- ☐ Stroke
- ☐ Depression

- ☐ Tuberculosis
- ☐ Thyroid problems
- ☐ Blood clots

During the past month have you been feeling down depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is there something with which you would like help? YES YES: BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone tried to hit you or injure you in anyway? YES NO

Motor vehicle accident or industrial injury with suspicion of fracture ☐ Yes ☐ No

Major fall with suspicion of fracture ☐ Yes ☐ No

Other: _____

Are you employed? ☐ Yes ☐ No

Work Status: ☐ Full-time work ☐ Part-time work ☐ Retired ☐ Out of work ☐ Work with limitations ☐ Work without limitations

If not working or limited in work capacity, length of time for work limitations_____

Workers Compensation involvement? ☐ Yes ☐ No

Litigation involvement? ☐ Yes ☐ No

Do you have any other information that would be useful? _____

_____

_____

Reviewed by therapist: _____ Date: _____