Elite Care PHYSICAL THERAPY Chesapeake Beach

Name: _____ Date: _____

CURRENT CASE HISTORY

Current Complaint: _____ **Date of Injury/Onset:** _____

Surgical Procedure: _____ **Surgery Date:** _____

How did your injury occur? _____

Check which applies to your condition:
☐ Work Related Injury ☐ Recurrence of Previous Injury ☐ Related to Falling
☐ Motor Vehicle Injury ☐ Related to Lifting ☐ Related to Surgery
☐ Unknown Cause ☐ Athletic/Recreational Injury ☐ Other: _____

Is your condition: ☐ Worsening ☐ Improving ☐ The Same

Check Symptoms you experience:
☐ Stiffness ☐ Popping ☐ Giving Away ☐ Dizziness
☐ Pressure ☐ Clicking ☐ Spasms ☐ Fainting
☐ Swelling ☐ Locking ☐ Loss of Motion ☐ Nausea

Pain at Least: No Pain 0 1 2 3 4 5 6 7 8 9 10 Take you to the hospital

Pain at Worst: No Pain 0 1 2 3 4 5 6 7 8 9 10 Take you to the hospital

Current: No Pain 0 1 2 3 4 5 6 7 8 9 10 Take you to the hospital

Describe the Pain: (Check all that Apply)
☐ Sharp ☐ Sore ☐ Burning ☐ Aching ☐ Intermittent
☐ Dull ☐ Throbbing ☐ Shooting ☐ Cramping ☐ Constant
☐ Pins ☐ Tingling ☐ Numbing

What makes it worse? _____ **Better?** _____

Time of day affect it? _____ **Wake you from sleep?** _____

Aggravating Factors:
☐ Standing ☐ Walking ☐ Kneeling ☐ Twisting ☐ Showering
☐ Sitting ☐ Squatting ☐ Bending ☐ Lifting ☐ Dressing
☐ Driving ☐ Stairs ☐ Reaching ☐ Carrying ☐ Chores

General Health: ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Treatments have Included:
☐ Aquatic Therapy ☐ Chiropractor ☐ Mechanical Traction ☐ Personal Training
☐ Athletic Training ☐ Injections ☐ Pain Management ☐ Surgical Intervention
☐ Brace/Tape ☐ Massage ☐ Other: _____ ☐ Home Health PT

Diagnostic Tests Performed for Current Complaint:
☐ X-Ray ☐ MRI ☐ CT Scan
☐ Bone Scan ☐ EMG ☐ Other: _____
☐ Ultrasound

Patient Goals: _____

CURRENT MEDICATION LIST

List ALL medications, supplements, vitamins & OTC you are currently taking:
(This must be completed prior to evaluation, please attach medication list if more are used)

Prescription	Dosage	Frequency	Notes

PAST MEDICAL HISTORY

Please check the Past, Present or Never for the following conditions:

Blood Pressure	PAST	NOW	NEVER	Other Conditions	PAST	NOW	NEVER
Hypertension (High)				Varicose Veins			
Hypotension (Low)				Gout			
Abnormal Blood Pressure				Hearing Loss			
Heart				Changes in Vision			
Heart Attack				Osteoporosis			
Atherosclerosis				Unusual Bleeding			
Heart Murmur				Unexpected Weight Loss			
Cardiac Bypass				Chest Pain			
Cardiac Stent				Depression			
Congestive Heart Failure				High Cholesterol			
Pacemaker				Metal Implants			
Blood Clot				Sleeping Difficulties			
Lungs				Bowel/Bladder Dysfunct.			
Asthma				Acid Reflux/Ulcer			
Emphysema				Kidney Disease			
Shortness of Breath				Lyme Disease			
COPD				Pregnant			
Joint Conditions				Hepatitis			
Dislocations				Lupus			
Scoliosis				Headaches/Migraines			
Rheumatoid Arthritis				STD/HIV			
Osteoarthritis				Cancer			
Fractures				Hernia			
Neurological				Recent Infection			
Multiple Sclerosis				Nausea/Vomiting			
Seizures/Epilepsy				Loss of Balance/Falling			
Change in Mental Abilities				Dizziness/Fainting			
Stroke				Unwarranted Fatigue			
Fibromyalgia				**Unlisted Conditions**			
Thyroid Disorder							
Diabetes							
Hypothyroidism							
Hyperthyroidism							

Exercise:
- ☐ None
- ☐ 1-2 x Week
- ☐ 3-4 x Week
- ☐ 5+ x Week

Work Activity Level:
- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Stress Level:
- ☐ Low
- ☐ Medium
- ☐ High

Lifestyle Habits:
- ☐ Smoking: _____ Packs a Day
- ☐ Alcohol: _____ Drinks per Wk
- ☐ Coffee/Soda: _____ Cups a Wk

Have you had any injuries related to work? ☐ Yes ☐ No Body part & date: _____

Have you had any auto accidents? ☐ Yes ☐ No Body part & date: _____

List all previous surgeries: _____

MEDICARE PATIENTS (complete this section if you are a Medicare Patient)

Patient Current Height: _____ ft _____ in **Patient Current Weight:** _____ lbs

To the best of my ability, I have given and included all necessary medical information.

Patient/Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____