PATIENT HEALTH SUMMARY

Name:____ Age:________ M F DOB:___________________________

Height _______________ Weight_____________ Hand Dominance: R / L *(circle one)*

Reason you are being seen today:____

Have you had any diagnostic testing for your current condition? If so, what tests:_____________________________________

Date of injury or when your symptoms began:_________________________________

How were you injured?____

Describe your current symptoms:____

What makes your symptoms worse?____

What makes you feel better?____

How long can you stand?_________________________ sit?_________________________ walk?___________________________

Have you experienced a fall within the past 12 months? [ ] Yes [ ] No If so, were you injured? [ ] Yes [ ] No

Do you have a previous history of the condition for which you are being seen today? Yes_____ No_____

What leisure/physical activities do you enjoy?____

What activities/movements can you no longer do due to your injury?____

What are your goals for therapy?____

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes_____ No_____

Medication/Injection and condition taken/given for: ____

____

Have you had <u>any</u> therapy in the ***past 12 months***? [ ] PT [ ] OT [ ] Speech [ ] Chiropractic [ ] Cardiac/Pulmonary **or** [ ] No

If yes, when was it?_________ How many?______ Was it at our clinic [ ] Yes [ ] No If no, where? ___________________________

Was it for the *same injury*? [ ] Yes [ ] No

Please check all that apply to you:

___ Cancer
___ Heart Condition
___ High BP/hypertension
___ Pacemaker
___ Asthma
___ Lung Disease
___ Emphysema
___ Hepatitis/kidney problems
___ Tuberculosis
___ Phlebitis/Circulatory Problems
___ Stroke
___ Anemia
___ Infectious Disease
___ Diabetes
___ Glaucoma
___ Thyroid Problems
___ Arthritis
___ Multiple Sclerosis
___ Neurological Disorder
___ Prostate Condition
___ Bowel/bladder
___ Emotional Problems
___ Migraines/headaches
___ Dizzy Spells
___ Seizure
___ Tobacco use

Are you currently pregnant? Yes_____ No_____

Is there anything else you feel we should be aware of? (fractures, other medical conditions)

____

List surgeries you have had:

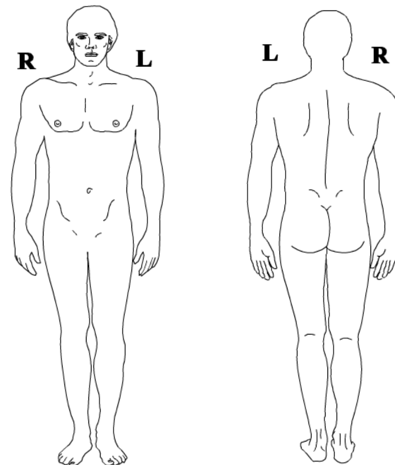
____

Circle the number that best describes your status:

PAIN 0 1 2 3 4 5 6 7 8 9 10

Best ______________________________________Worst

Please shade in the areas where you are experiencing pain:



Please notify your therapist if there are any changes in your condition.
Thank you for coming to our clinic for your therapy needs.

Patient Signature ____ Date ______________________