Creekside
Physical Therapy

Patient Health History and Information

Date: ________ Name: ______________________________
DOB: ________________ Acct: ____________________
Insurance:

Age: _____ **Height:** _______ **Weight:** _____ **Sex:** M F **Pronouns:** He/Him She/Her They/Them

Dominant hand: R L **Could you be or are you pregnant:** Yes No

Reason for Therapy: ____ **Date of injury or onset of symptoms:** ___/___/___

Please describe how your injury/problem occurred: ____

Surgery for *this condition*: Y / N **Date:** ___/___/___ **Type:** _________________________________

Please list any treatment you have received for this condition (ie. therapy, chiro): ______________________________

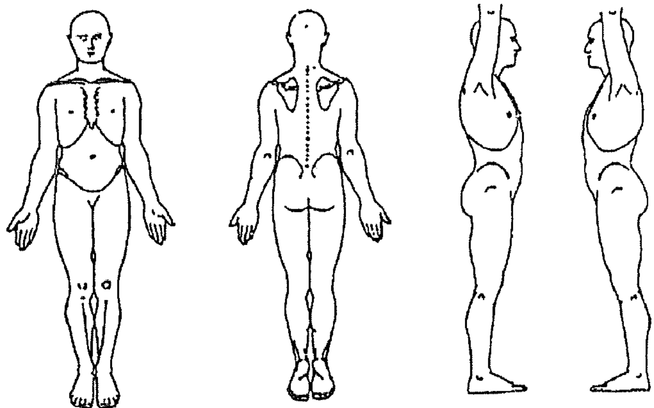
For this condition, have you had any of the following? X-ray MRI CT scan EMG Injection Other: __________

Have you had this problem before? Y / N When? __________ Any prior treatment? (ie. therapy, chiro): __________________

Surgical History (Please list *any* surgeries): ____

Using the key below indicate on the body diagrams where your symptoms are located.

X=Pain **//**= Numbness **O**=Tingling



Please rate your pain (0=none, 1=minimal, 10=severe)

At present:	0	1	2	3	4	5	6	7	8	9	10
At worst:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

Please describe CIRCLE your pain/symptoms

Constant	Intermittent	Sharp	Dull	Aching	Burning
Decreasing	Increasing	Staying the same			
Weakness	Giving way	Throbbing	Other:______________		

Which side are we seeing you for?: Right Left

What makes your symptoms worse ____

What makes your symptoms better? ____

Limitations due to your current problem: ____

____Laying down
____Sit to stand
____Up/Down Stairs
____Squatting/Lifting
____Looking overhead
____Taking a deep breath
____Bending
____Work
____Driving
____Swallowing
____Talk/Chew/Yawn/All
____ Cough/sneeze pain
____Turning Head
____Sitting
____Walking
____Standing
____Reaching
____Child care
____Sleeping
____Self Care/Hygiene
____Home activities
____Repetitive activities
____Sport/Recreation

What are your goals for therapy? (Two things you want to be able to do again or do better)

1.____ **2.** ____

Who referred you to Physical Therapy? ____________________ **Primary Physician**: ________________________

How did you hear about Creekside Physical Therapy? Physician Friend/relative Website Previous patient Self Coach Other

Date:________ Name:______________________________

D.O.B.________ Patient Account ________________
Insurance: ____

GENERAL HEALTH HISTORY:

Since your symptoms began have you had any of the following:

Fever / Chills	Yes	No
Nausea / Vomiting	Yes	No
Numbness genital/anal area	Yes	No
Dizziness / Fainting	Yes	No
Unexplained weakness	Yes	No
Headaches	Yes	No
Unexplained weight change	Yes	No
Night sweats / pain	Yes	No
Problems with vision / hearing / speech	Yes	No
Difficulty with bowel/bladder function	Yes	No
Other: ______________________	Yes	No

Have you had any falls or near falls in the past year? ___Yes ___No **Living Situation:** Alone Spouse Family Others

Rate your overall health: Excellent Good Average Poor **Rate your current stress levels:** Low Medium High

Do you exercise? Yes No _____x/week Type:______________________________

Do you smoke? Yes No **Do you drink caffeinated beverages?** Yes No ____/week

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Occupation/job title: ______________________ Self Student Full time Part time Retired Unemployed

Physical activities at work: Sitting Standing Computer use Phone use Repetitive/Heavy lifting Other:____________

Employer:__________________________ **Current work duty:** Full duty Restricted duty **Work days missed:** ______

QRC and/or Adjuster (if you have one):______________________________

Have you or anyone in your immediate (brother, sister, parent, grandparent) **family ever been diagnosed with any of the following:**

Allergies/asthma	Self	Family	No
Anxiety	Self	Family	No
Cancer	Self	Family	No
High Cholesterol	Self	Family	No
High blood pressure	Self	Family	No
Heart trouble/angina	Self	Family	No
Diabetes	Self	Family	No
Stroke	Self	Family	No
Osteoporosis	Self	Family	No
Osteoarthritis	Self	Family	No
Rheumatoid arthritis	Self	Family	No
Depression	Self	Family	No
Headaches	Self	Family	No
Stomach/GI problems	Self	Family	No
Kidney problems	Self	Family	No
Thyroid problems	Self	Family	No
Epilepsy/dizziness	Self	Family	No
Tuberculosis	Self	Family	No
Anemia/blood disorder	Self	Family	No
Multiple Sclerosis/Neurologic	Self	Family	No
Circular/vascular problems	Self	Family	No
Chemical dependency	Self	Family	No
Pace maker/metal implants	Self	Family	No
AIDS/HIV	Self	Family	No
Hepatitis	Self	Family	No
Bladder/bowel problems	Self	Family	No
COVID-19	Self	Family	No
Lyme Disease	Self	Family	No

Other:______________________________

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest in the pleasure of doing things: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day
2. Feeling down, depressed or hopeless: **0**- Not at all **1**- Several days **2**- More than half the days **3**- Nearly every day

Are there any other issues/concerns that you think we should know about that may or may not affect your ability to benefit from physical/occupational therapy treatment: No _____ Yes ______________________

Patient Signature: ______________________ **Date** ____/____/____

Reviewed by Therapist: ______________________ **Date** ____/____/____

MD follow-up: ____/____/____ ☐ None Scheduled

With-in 90 days of last Medical history completion (date and initial any changes)
– Medical History reviewed by patient, changes noted and reviewed by therapist.

Patient Signature:______________________ **Date** ____/____/____

Reviewed by Therapist: ______________________ **Date** ____/____/____

Patient Name:	Date of birth:	Date Completed:
Allergies/Adverse effects to medications:		

1. In order to provide optimal care it is important for us to maintain an up-to-date list of all your medications .
2. Please fill out the chart below. ****If you already have a complete list of your medications, please bring it and we will make a copy in lieu of completing this form.**

Name of prescription medication (brand or generic)	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)
Example: *Lasix*	*20 mg.*	*High blood pressure*	*Two times a day*	*By mouth*

Over the Counter medication or nutritional supplements	Dosage	Why are you taking this medication?	How often do you take it?	How do you take it? (by mouth, injection, etc.)

Patient updated:	Date:	Patient updated:	Date:
Therapist reviewed:	Date:	Therapist reviewed:	Date: