Creekside
Physical Therapy

Date: _____ Name: _____

DOB: _____ Patient Account # _____

Patient Health History and Information

Date: ___/___/___ Age: _____ Height: _____ Weight: _____ Dominant hand: R L Could you be or are you pregnant: Yes No

Sex: M F Reason for Therapy: _____

Please describe how your injury/problem occurred (i.e. fall, activity, work, auto, unknown): _____

Date of injury or onset of symptoms: ___/___/___ Recent surgery? Yes No Date: ___/___/___ Type: _____

Please list any treatment you have received for this condition (i.e. Therapy, Chiropractor): _____

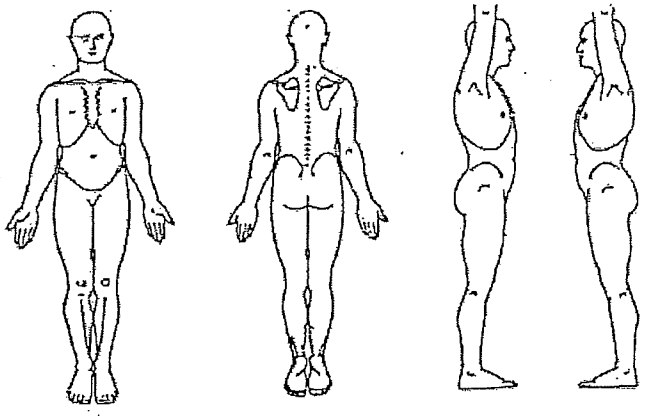
For this condition have you had any of the following? None X-ray ___/___/___ MRI / CT scan ___/___/___

Injection: type: _____ ___/___/___ Surgery: type: _____ ___/___/___ Other: _____ ___/___/___

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 your pain/symptoms

Constant Intermittent Increasing
Decreasing Staying the same

Sharp Dull Aching Burning
Weakness Throbbing Other: _____

Which side are we seeing you for?: Right Left

What makes your symptoms worse? (i.e. heat, cold, rest, activity) _____

What makes your symptoms better? (i.e. heat, cold, rest, activity) _____

Please indicate your current limitations due to injury:

____ Sitting: _____ ____Standing: _____ ____Sleeping: _____

____ Going from sit to stand ____ Walking _____ ____ Lying down ____ Up/Down stairs

____ Reaching _____ ____ Squatting ____ Bending ____ Looking overhead

____ Taking a deep breath ____ Swallowing ____ Talking / Chewing / Yawning / All (circle one)

____ Turning head ____ Driving ____ Work

____ Self care / Hygiene _____ ____ Home activities _____

____ Repetitive activities _____ ____ Sports / Recreation _____

____ Other: _____

What are your goals for therapy? _____

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

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

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:

Have you had any falls or near falls in the past year? _____ Yes ____ No

Rate your overall health: Excellent Good Average Poor **Do you exercise?** Yes No _____x/week

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

Living Situation: Alone Spouse Family Others

Rate Your Stress Level: Low Medium High

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:** _____

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

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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 effect your ability to benefit from physical/occupational therapy treatment: ___Yes ____No _____

_____

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** ____/____/____

Creekside
Physical Therapy

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: