

## PHYSICAL THERAPY PATIENT HISTORY

**Name:**

\_\_\_\_\_

Last First MI Jr./Sr., etc

**Age:** \_\_\_\_\_

**Sex:** Male  Female

**Language:**  English Understood  
 Interpreter Needed  
 Language spoken most often  
\_\_\_\_\_

**Hand Dominance:**  
 Right Handed  
 Left Handed

**EMPLOYMENT / WORK STATUS**

- Working full-time outside of home     Working part-time outside of home  
 Working full-time from home     Working part-time from home  
 Homemaker     Student  
 Retired     Unemployed

**SOCIAL & HEALTH HABITS**

a) Smoking? Yes  No   
# packs/day \_\_\_\_\_  
# cigars/pipes a day \_\_\_\_\_  
Smoked in past?  Yes  No  
Year Quit \_\_\_\_\_

b) Alcohol  
#days/ week you drink on average \_\_\_\_\_  
# of drinks you have on average day \_\_\_\_\_

c) Exercise  
Do you exercise beyond daily activities and chores?  
Yes (describe exercise) \_\_\_\_\_  
# days/ week you exercise \_\_\_\_\_ # Minutes \_\_\_\_\_  
No exercise \_\_\_\_\_

**GENERAL HEALTH STATUS**

Please rate your health:

Excellent  Good  Fair  Poor

Family History (and relation to you):

- Heart Disease \_\_\_\_\_  
 Hypertension \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Cancer \_\_\_\_\_  
 Psychological \_\_\_\_\_  
 Arthritis \_\_\_\_\_  
 Osteoporosis \_\_\_\_\_  
 Other \_\_\_\_\_

**Other Clinical Tests in Past Year**

- MRI     Biopsy     EKG     Blood test  
 CT Scan     Bone Scan     X-rays     Stress test  
 NCV/EMG     Myelogram     Urine test

**Medical / Surgical History**

Check if you have or have had:

- Arthritis \_\_\_\_\_ Seizures \_\_\_\_\_
- Fractures \_\_\_\_\_ Osteoporosis \_\_\_\_\_
- Growth Problems \_\_\_\_\_ Blood Disorders \_\_\_\_\_
- Allergies \_\_\_\_\_ Circulatory Problems \_\_\_\_\_
- Thyroid Problems \_\_\_\_\_ Heart Problems \_\_\_\_\_
- Cancer \_\_\_\_\_ High Blood Pressure \_\_\_\_\_
- Infectious Diseases \_\_\_\_\_ Lung Problem \_\_\_\_\_
- Kidney Problems \_\_\_\_\_ Stroke \_\_\_\_\_
- Ulcers \_\_\_\_\_ Diabetes \_\_\_\_\_
- Skin Diseases \_\_\_\_\_ Hypoglycemia \_\_\_\_\_
- Depression \_\_\_\_\_ Multiple Sclerosis \_\_\_\_\_
- Pacemaker \_\_\_\_\_ Muscular Dystrophy \_\_\_\_\_
- Other \_\_\_\_\_ Parkinson's Disease \_\_\_\_\_

**Other Medical Care**

Are you seeing anyone else for your problem?

\_\_\_\_\_

**Functional Status**

- Difficulty walking up stairs \_\_\_\_\_
- Difficulty getting in and out of bed \_\_\_\_\_
- Difficulty getting up from a chair \_\_\_\_\_
- Difficulty on level ground \_\_\_\_\_
- Difficulty walking up or down inclines \_\_\_\_\_
- Difficulty bathing or dressing \_\_\_\_\_
- Difficulty with house chores \_\_\_\_\_

**Have you ever had surgery?** Yes \_\_\_ No \_\_\_

**Additional Comments:**

- 1)Date: \_\_\_\_\_ Surgery \_\_\_\_\_
- 2)Date: \_\_\_\_\_ Surgery \_\_\_\_\_
- 3)Date: \_\_\_\_\_ Surgery \_\_\_\_\_
- 4)Date: \_\_\_\_\_ Surgery \_\_\_\_\_

**Within the past year, have you had these symptoms?**

**Prescription Medications:**

- Chest Pain \_\_\_\_\_ Difficulty Swallowing \_\_\_\_\_
- Heart Palpitations \_\_\_\_\_ Bowel Problems \_\_\_\_\_
- Shortness of Breath \_\_\_\_\_ Urinary Problems \_\_\_\_\_
- Dizziness/Blackouts \_\_\_\_\_ Headaches \_\_\_\_\_
- Loss of Balance \_\_\_\_\_ Vision Problems \_\_\_\_\_
- Generalized Weakness \_\_\_\_\_ Hearing Problems \_\_\_\_\_
- Difficulty Sleeping \_\_\_\_\_ Cough/hoarseness \_\_\_\_\_
- Nausea/Vomiting \_\_\_\_\_ Loss of appetite \_\_\_\_\_
- Weight loss/gain \_\_\_\_\_ Fever chills/sweats \_\_\_\_\_
- Coordination Problems \_\_\_\_\_ Joint pain or swelling \_\_\_\_\_
- Pain at night \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Over the Counter Medications:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Condition/Chief Complaint**

Describe the problems for which you seek physical therapy:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Date of onset \_\_\_\_\_