KINETIC PHYSICAL THERAPY
& Human Performance Center

PATIENT HISTORY FORM

FOR THIS CURRENT YEAR HAVE YOU HAD:

PT services at another clinic? Y N ____/____ to ____/____

Home care? Y N ____/____ to ____/____

Speech therapy? Y N ____/____ to ____/____

NAME:____ **DATE:**____________________

AGE:________ **SEX:** M F **HEIGHT:**__________ **WEIGHT:**__________ **DOMINANT HAND:** R L

WORK INFORMATION:

Occupation______________________________________ Presently Working: Y N

How did your problem occur? ____

____

Date of onset? ____/____/_______ Involved Side: R L BOTH

Describe any previous problems with this area_________________________________

MEDICAL INFORMATION:

Referring Doctor:______________________________Family Doctor____________________

Medical Test(s): X-Ray______ CAT Scan______ Bone Scan______ MRI______ Other__________________

Results____

Recent surgery? Y N Date____/____/_______ Where_________________________________

Did you use: Cast_____ Splint_____ Brace_____ Date Applied____/____/_______ Date Removed____/____/_______

Have you ever been diagnosed with any of the following conditions?

Y	N	Cancer
Y	N	Heart or Circulation Problems
Y	N	High Blood Pressure
Y	N	Depression/Anxiety/OCD
Y	N	Asthma
Y	N	Eating Disorder
Y	N	Thyroid Problems
Y	N	Diabetes
Y	N	Lyme Disease
Y	N	Other Arthritic Condition
Y	N	Hepatitis
Y	N	Stroke
Y	N	Latex Allergy
Y	N	Anemia
Y	N	Multiple Sclerosis
Y	N	Osteoporosis/Osteopenia
Y	N	Concussion

MEDICAL INFORMATION: (Continued)

In the past 3 months, have you had or do you experience:

Y	N	A change in health	Y	N	Difficulty swallowing
Y	N	Nausea/Vomiting	Y	N	Changes in bowel or bladder function
Y	N	Fever/Chills/Sweats	Y	N	Shortness of Breath
Y	N	Unexplained weight change	Y	N	Dizziness
Y	N	Numbness/ tingling	Y	N	Upper Respiratory infection
Y	N	Changes in Appetite	Y	N	Urinary tract infection

Are you currently pregnant? Y N

Do you smoke? Y N How much? ___________ Do you drink? Y N How much?___________

If you are 65 or older, have you fallen in the past 12 months? Y N If yes, how many times?_________________

Did your fall result in any injury(s)? Y N Please explain____

____

____

____

____

List any medications you are currently taking:
(Please include prescriptions, over-the-counter, herbals, vitamin/mineral/dietary supplements)

Name of Med./Supplement	Dosage	Frequency of Use	Route of Administration
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

*If necessary, please continue on the reverse side.

FUNCTION:

Identify (3) activities that are important to you and your ability to currently perform that activity:

Activity #1:____

(Unable to perform) 0 1 2 3 4 5 6 7 8 9 10 (Able to perform at pre-injury level)

Activity #2:____

(Unable to perform) 0 1 2 3 4 5 6 7 8 9 10 (Able to perform at pre-injury level)

Activity #3:____

(Unable to perform) 0 1 2 3 4 5 6 7 8 9 10 (Able to perform at pre-injury level)

What goals do you hope to accomplish with Physical Therapy?____

Circle the amount of your pain at its worst: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Circle the amount of your pain at its best: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

Circle the amount of your pain currently: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)

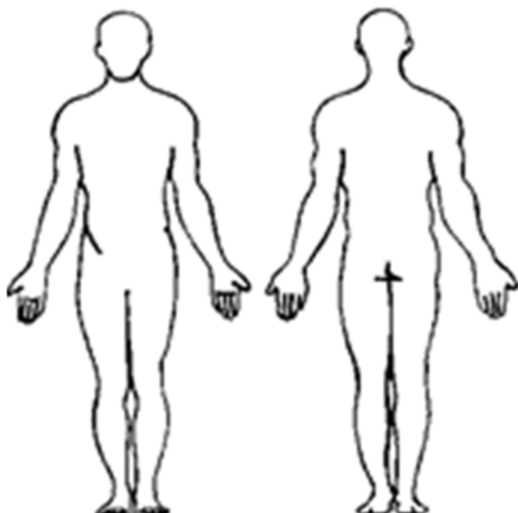
Is your pain: _____Constant _____Intermittent

How are you able to sleep at night? ◯ Fine ◯ Moderately Difficult ◯ Only with Medication

Activities that increase pain:____

Activities that decrease pain:____

Please mark on the drawing and/or lists below the areas where you feel your pain:



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

Little interest or pleasure in doing things:

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3

Feeling down, depressed or hopeless:

Not at all	Several days	More than half the days	Nearly every day
0	1	2	3