Performing Arts Physical Therapy - Patient History

Date_____

Name: _____ Date of Birth: _____ Age: _____

Address:_____ Phone: _____

Email:_____

Occupation:_____ Height: _____ Weight:_____

Are you on a work restriction from your doctor?(circle) Yes No
Is there litigation involved regarding this injury or condition? (circle) Yes No
Do you exercise, if so, what do you do, and hours per week?_____
Do you smoke? (circle) Yes No Do you drink alcohol, if yes, drinks per week?_____
Do you have a pacemaker?(circle) Yes No
FOR WOMEN: Are you currently pregnant or think you might be pregnant?(circle) Yes No

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Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ loss of balance/falls
- ❑ chest pain
- ❑ change in appetite
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ fibromyalgia
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ Parkinson's disease
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems/hepatitis
- ❑ seizures
- ❑ other:_____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ blood clots
- ❑ thyroid problems
- ❑ depression
- ❑ autoimmune disease

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
If yes, is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

_____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**
Please list any surgeries or major illnesses for which you have been hospitalized, including dates:

1. _____
2. _____
3. _____

Describe your problem (why you came to physical therapy), if more than one, label #1 as primary problem.

_____

What date (roughly) did your present symptoms start?_____

What do you think caused your symptoms? _____

My symptoms are currently: ❑ Getting Better ❑ Getting Worse ❑ Staying about the same

My symptoms currently: ❑ Come and go ❑ Are constant ❑ Are constant, but change with activity

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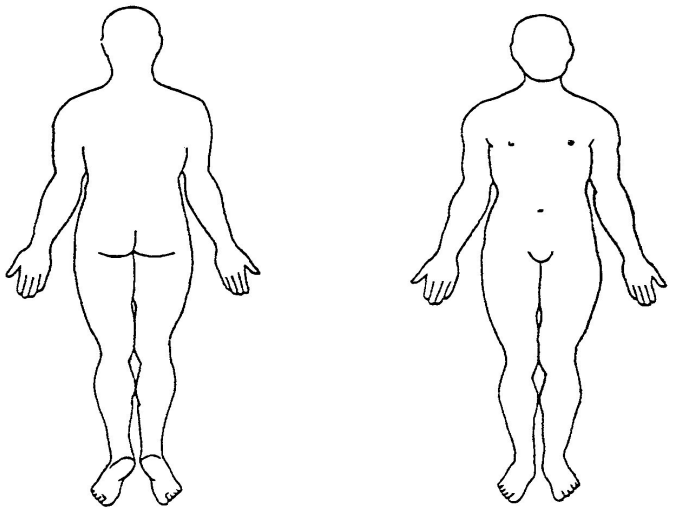
Body Chart:

Please mark the areas where you feel symptoms.

You may use the following symbols
to describe your symptoms:

↓ **Sharp pain**
O Aching pain
||| **Numbness**
= Tingling



What makes your problem worse? (for example, sitting more than 15 min, bending, twisting)
1. _____
2. _____
3. _____

What eases/improves your problem? (for example, lying on side, taking medication, icing)
1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

On the scales below, please circle the number which best represents the severity of your #1 pain:

***Currently*:** **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**
***Best* for the last 48 hours:** **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**
***Worst* for the last 48 hours:** **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Treatment received so far for this problem (chiropractic, injections, etc) _____
What treatment(s) helped?_____
What treatment(s) made it worse?_____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ Yes ❑ No When:_____ **Treatment rec'd:**_____

How long did it take for you to feel better? _____

What are your physical therapy treatment goals? _____

_____