Performing Arts Physical Therapy
The Pilates Studio® of Los Angeles

1106 N. La Cienega Blvd., Ste. 203
West Hollywood, CA 90069
Tel 310-659-1077 · Fax 310-659-1163
info@pilatestherapy.com

Patient History

Name: _____ Date of birth: _____ Age: _____ Date: _____

Address: _____ Phone: _____

Email: _____ Occupation: _____

Height: _____ Weight: _____

Are you on a work restriction from your doctor? ☐ Yes ☐ No

Is there litigation involved regarding this injury or condition? ☐ Yes ☐ No

Do you exercise? If so, what do you do, and how many hours per week? _____

Do you smoke? ☐ Yes ☐ No

Do you drink alcohol? If yes, drinks per week: _____

Do you have a pacemaker? ☐ Yes ☐ No

For women: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

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 (e.g., 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

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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

Surgeries or major illnesses for which you were hospitalized (include dates)

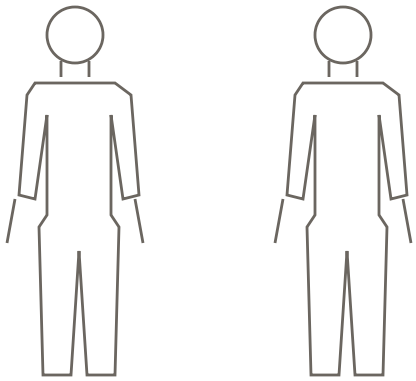
1. _____
2. _____
3. _____

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



Please mark the areas where you feel symptoms. You may use these symbols:

↓ Sharp pain
O Aching pain
||| Numbness
≡ Tingling

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What makes your problem worse? (for example, sitting more than 15 min, bending, twisting)

1. _____
2. _____
3. _____

What eases or 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 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 in the last 48 hours:	No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Worst in 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? _____

Special tests performed for this problem (x-ray, MRI, labs, etc.): _____

Have you had this problem before? ☐ Yes ☐ No When: _____ Treatment received: _____

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

What are your physical therapy treatment goals?

_____

_____