**PATIENT HISTORY**

**Patient’s Name** (First, Middle, Last)  

**Home Therapy:** Are you currently receiving health care services in your home that are billed to your insurance?  

- [ ] Yes  
- [ ] No

**EMAIL:** (for exercise program):

**Other Treatment:** Have you received any of these treatments this year?  

- [ ] Physical/Occupational/Speech Therapy  
- [ ] Chiropractic/Spinal Manipulation  
- [ ] OMM (Osteopathic Manipulative Medicine)

**Reason for Visit (Describe Injury):**  

**Goal (What do you want to do better with therapy?):**  

**Date of Onset:**

**Onset/Timing:**  

- [ ] Gradual Onset  
- [ ] Sudden Onset

**How did your pain/problem start?**  

- [ ] Unknown  
- [ ] While Lifting  
- [ ] Car Accident  
- [ ] A Fall  
- [ ] Trauma  
- [ ] Overuse  
- [ ] Degenerative Process  
- [ ] Recreation/Sport:  
- [ ] Dental Appt  
- [ ] Other:

**Severity of pain/problem:**  

- [ ] Improving  
- [ ] Not Changing  
- [ ] Worse

**Current Pain:** ___/10  

**Highest pain in past 2 weeks:** ___/10  

**Lowest pain in past 2 weeks:** ___/10

**Pain is:**  

- [ ] Constant  
- [ ] Intermittent  
- [ ] Variable in Intensity  
- [ ] Activity Dependent

**Describe your pain/symptoms:**  

- [ ] Sharp  
- [ ] Periodic  
- [ ] Dull  
- [ ] Occasional  
- [ ] Throbbing  
- [ ] Constant  
- [ ] Aching  
- [ ] Painful/Stiff when getting out of bed  
- [ ] Other:

**Throughout the day, my pain/problem:**  

- [ ] Increases  
- [ ] Decreases  
- [ ] Stays the same

**Wake up at night when:**  

- [ ] lying still  
- [ ] changing positions  
- [ ] lying still and changing positions

**Sleeping Position:**  

- [ ] Back, sides and stomach  
- [ ] on right side  
- [ ] on left side  
- [ ] on back  
- [ ] chair/recliner

**Within the past year, have you had any of the following symptoms?** (check all that apply)  

- [ ] Unable to control bowel/bladder  
- [ ] Fever/Chills  
- [ ] Dizziness/Fainting  
- [ ] Unexplained Weakness  
- [ ] Numbness of Genitalia  
- [ ] Unexplained change in weight  
- [ ] Night Pain/Sweats  
- [ ] Malaise  
- [ ] Vision Problems  
- [ ] Numbness  
- [ ] Hearing Problems  
- [ ] Other:

**Aggravating Factors (check all that apply):**  

- [ ] Sitting  
- [ ] Looking Up Overhead  
- [ ] Repetitive Activity  
- [ ] Sustained Bending  
- [ ] Chewing  
- [ ] Other:

- [ ] Going to/raising from sitting  
- [ ] Reach Overhead  
- [ ] Household Activities  
- [ ] Cough  
- [ ] Swallowing  
- [ ] Other:

- [ ] Walking  
- [ ] Reach In Front  
- [ ] Sports/Recreation  
- [ ] Deep Breathing  
- [ ] Yawning  
- [ ] Other:

- [ ] Up/Down Stairs  
- [ ] Reach Behind Back  
- [ ] Standing  
- [ ] Sleeping  
- [ ] Stress  
- [ ] Lying Down  
- [ ] Reach Across Body  
- [ ] Squatting  
- [ ] Talking

**Alleviating Factors (check all that apply):**  

- [ ] Nothing  
- [ ] Cold  
- [ ] Heat  
- [ ] Sitting  
- [ ] Exercise  
- [ ] Meditation  
- [ ] Standing  
- [ ] Massage  
- [ ] Wearing a splint/orthotics  
- [ ] Rest  
- [ ] Lying Down  
- [ ] Stretching  
- [ ] Other:

Please map your areas of discomfort or altered sensation on the body map.  

- [ ] XXX = Pain  
- [ ] 000 = Numb/Tingle/Radiating  
- [ ] *** = Weakness
<table>
<thead>
<tr>
<th>Medical/Surgical History</th>
<th>Please check all that apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD</td>
<td>Back Pain</td>
</tr>
<tr>
<td>AIDS/HIV</td>
<td>Bleeding Disorder</td>
</tr>
<tr>
<td>Allergies/Hayfever</td>
<td>Brain Injury</td>
</tr>
<tr>
<td>Ankle Sprains</td>
<td>Cancer</td>
</tr>
<tr>
<td>Ankylosing spondylitis</td>
<td>Carpal Tunnel</td>
</tr>
<tr>
<td>Anxiety/Depression</td>
<td>Cystic Fibrosis</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Developmental Delay</td>
</tr>
<tr>
<td>Asthma</td>
<td>Diabetes</td>
</tr>
<tr>
<td>Surgery History: (please list &amp; include dates (mo/year)):</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Do you take prescription or nonprescription medication?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>If yes, please list below or attach a list.</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medications:</th>
<th>Prescription</th>
<th>Non-prescription</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Allergies:</th>
<th>Do you have any allergies?</th>
<th>None</th>
<th>Bees</th>
<th>Latex</th>
<th>Perfumes/lotions</th>
<th>Coconut</th>
<th>Pine/linden</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adhesive/tapes</td>
<td>Other (please specify):</td>
<td></td>
<td></td>
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(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

<table>
<thead>
<tr>
<th>Social History:</th>
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</thead>
<tbody>
<tr>
<td>Smoking Status:</td>
</tr>
<tr>
<td>Employment/Work (job/school):</td>
</tr>
<tr>
<td>Occupation:</td>
</tr>
<tr>
<td>Exercise Level:</td>
</tr>
</tbody>
</table>

(Please include type of exercise, days/wk, and average # minutes)

<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>Unknown</th>
<th>Married</th>
<th>Single</th>
<th>Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Living Status:</td>
<td>Alone</td>
<td>Live with others</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Single/Multi-level home/work:</th>
<th>Single-level home</th>
<th>Multi-level home</th>
<th>Single-level work</th>
<th>Multi-level work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Related Injury:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>Auto Related Injury:</td>
<td>Yes</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Able to care for self:</td>
<td>Yes</td>
<td>No (if no, who cares for you?)</td>
<td></td>
<td></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Patient signature:</th>
<th>Date:</th>
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<thead>
<tr>
<th>Therapist Signature:</th>
<th>Date:</th>
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