**PATIENT HISTORY**

**Legal 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

**Chosen Name:**

**Pronouns (circle):** he/him/his [ ] she/her/hers [ ] they/them/their

**Other Treatment:** Have you received any of these treatments this year? [ ] Physical/Occupational/Speech Therapy [ ] Chiropractic/Spinal Manipulation [ ] OMM (Osteopathic Manipulative Medicine)

**Work Related Injury:** [ ] Yes [ ] No

**Auto Related Injury:** [ ] Yes [ ] No

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

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

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

**Date of Onset:**

**Onset/Timing:** [ ] Number of Prior Episodes: [ ] Gradual Onset [ ] Sudden Onset

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

[ ] Unknown [ ] While Lifting [ ] Car Accident [ ] A Fall

[ ] Trauma [ ] Overuse [ ] Degenerative Process [ ] Recreation/Sport:

[ ] 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 [ ] Dull [ ] Throbbing [ ] Aching

[ ] Periodic [ ] Occasional [ ] Constant [ ] 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 stomach [ ] 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 [ ] Numbness of Genitalia [ ] Numbness

[ ] Dizziness/Fainting [ ] Unexplained Weakness [ ] Unexplained change in weight [ ] Night Pain/Sweats

[ ] Malaise [ ] Vision Problems [ ] Hearing Problems

**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

[ ] Walking

[ ] Reach In Front

[ ] Sports/Recreation

[ ] Deep Breathing

[ ] Yawning

[ ] Up/Down Stairs

[ ] Reach Behind Back

[ ] Standing

[ ] Sleeping

[ ] Stress

[ ] Lying Down

[ ] Reach Across Body

[ ] Squatting

[ ] Talking

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

[ ] Rest

[ ] Cold

[ ] Nothing

[ ] Heat

[ ] Sitting

[ ] Wearing a splint/orthotics

[ ] Walking

[ ] Lying Down

[ ] Stretching

[ ] Exercise

[ ] Standing

[ ] Massage

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

XXX = Pain

000 = Numb/Tingle/Radiating

*** = Weakness

--- OVER ---
**MEDICAL/SURGICAL HISTORY:** a. Please check all that apply

| Condition                  |  | Condition                  |  |
|----------------------------|  |----------------------------|  |
| ADD                        |  | Back Pain                  |  |
| AIDS/HIV                   |  | Epilepsy/Seizures          |  |
| Allergies/Hayfever         |  | Hypertension               |  |
| Ankle Sprains              |  | Lung Disease               |  |
| Ankylosing spondylitis     |  | Malignancy                 |  |
| Anxiety/Depression         |  | Rheumatoid Arthritis       |  |
| Arthritis                  |  | Renal Failure              |  |
| Asthma                     |  | Rheumatoid                      |
| Surgery History: (please list & include dates (mo/year)): |

**MEDICATIONS:** Do you take prescription or nonprescription medication? □ YES, □ NO  If yes, please list below or attach a list.

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

**ALLERGIES:** Do you have any allergies? □ None □ Bees □ Latex □ Perfumes/lotions □ Coconut □ pine/linden □ Adhesive/tapes □ Other (please specify):

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

**SOCIAL HISTORY:**

<table>
<thead>
<tr>
<th>Smoking Status: □ Never □ Former □ Current Everyday □ Current Some Day □ Smoker – Status Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment/Work (job/school): □ Full time □ Part time □ Retired □ Student □ Unemployed □ Disability</td>
</tr>
<tr>
<td>Occupation: □ Full time □ Part time □ Retired □ Student □ Unemployed □ Disability</td>
</tr>
<tr>
<td>Exercise Level: □ None □ Occasional □ Moderate □ Heavy</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Marital Status: □ Unknown □ Separated □ Married □ Single □ Divorced</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Children: □ Domestic Partner □ Student □ Unemployed □ Disability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Living Status: □ Alone □ Live with others □ Pet(s): (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single/Multi-level home/work: □ Single-level home □ Multi-level home</td>
</tr>
<tr>
<td>Able to care for self: □ Yes □ No (if no, who cares for you?)</td>
</tr>
</tbody>
</table>

**Patient signature:** Date:

**Therapist Signature:** Date: