FOOTHILLS
Physical Therapy

PATIENT HISTORY FORM

Name: _____ D.O.B _____ Age: _____

*****Have you received or currently in Home Health or Physical Therapy? YES NO**
If Yes, what was the date range?_____ How many visits? _____
(Please be aware Home Health or attending another Physical Therapy office may count towards your visit maximum.)

Current Conditions/Chief Complaint: _____

_____

When did the problem begin? _____

What happened? _____

_____

Have you ever had this problem before? If yes, explain. _____

_____

What aggravates or makes your problem worse? _____

_____

What eases or makes your problem better? _____

_____

What are you currently doing to make your problem better? _____

_____

What are your goals for physical therapy? _____

_____

Functionally, what are you having difficulty with?
(For example: driving, walking, prolonged sitting, lifting, working….) _____

_____

Current Medication (please list all): _____

_____

Are you allergic to any medications? (please list all): _____

_____

(Complete on back)

Medical History: _____

_____

_____

Surgical History: _____

_____

_____

Are you experiencing any of the following?

Fever/chills/sweats	**Y**	**N**
Nausea/vomiting	**Y**	**N**
Dyspnea (difficulty breathing)	**Y**	**N**
Syncope/dizziness	**Y**	**N**
Recent onset of weakness	**Y**	**N**
Recent change in bowel or bladder control	**Y**	**N**

Functional / Social Questions:

Are you currently working? **Y N**

Full duty, no limitations? **Y N**

If not working, how long have you been out of work?
_____

-Difficulty with self-care? **Y N**

-Difficulty with home management (shopping, care of dependents, chores, etc.)? **Y N**

-Difficulty with work activities? **Y N**

With whom do you live? (circle one)
Alone Spouse Group setting Caregiver, Child(ren) Other_____

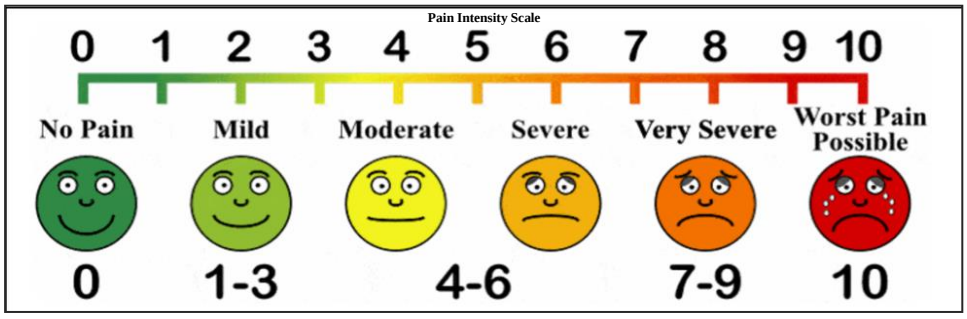
- Do you feel you need social services/counseling for any of these concerns? **Y N**

Have you undergone any diagnostic testing for this problem (x-rays, MRI, CT Scan, EMG, etc.)?

_____

Please refer to the Pain Intensity Scale to rate your pain in the boxes below.

At Best ☐ **At Worst** ☐ **Average** ☐ **At This Moment** ☐



Please mark on the body chart the site(s) of pain for which you are seeking physical therapy.