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PATIENT HISTORY FORM

_ D.O.B	Age:
orking)	
	orking)

Medical History:		
Surgical History:		
-		
Are you experiencing any of th	ne fol	llowing?
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 Questi	ons:	
Are you currently working?	Y	N
Full duty, no limitations?	Y	N
If not working, how long have you been o	out of w	ork?
-Difficulty with self-care?	Y	N
-Difficulty with home management (shop dependents, chores, etc.)?		are of N
-Difficulty with work activities?	Y	N
With whom do you live? (circle one) Alone Spouse Group setting Child(ren) Other	Careg	giver,
- Do you feel you need social services/conthese concerns?	unselinį Y	g for any of 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.

At Best		At Worst		Average		At This Moment	
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0	No Pain		
1	Lowy No poin medications. Normal layels of activity		
2	Low: No pain medications. Normal levels of activity, except for heavy types.		
3	except for neavy types.		
4	Moderate: Regular use of pain medications and possibly muscle		
5	relaxants. Activity is very limited, but functional for family &		
6	social roles.		
7	High Decylor was of main anti-inflammatory & muscle relevant		
8	 High: Regular use of pain, anti-inflammatory & muscle relaxa medication. Activity limited to necessary self-care. 		
9	medication. Activity infinited to necessary sen-care.		
10	Emergency Situation		

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

