PT360
EXCELLENCE IN MOTION

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Today's Date:_______________

Medical History

Date of Injury:_______________

Primary complaint(s)? ______________________ Date of onset: _______________

Surgery Performed? ☐ Yes ☐ No If Yes, Date/Type of Surgery: ________________

Have you been hospitalized for this complaint? ☐ Yes ☐ No If Yes, date range: ____________

Is your injury related to a fall? ☐ Yes ☐ No If Yes, date of fall: ____________

Symptoms

What are your symptoms related or due to?

☐ Work ☐ Overuse ☐ Other: ___________________

☐ Auto accident ☐ Trauma

☐ Sports Injury ☐ Chronic

What aggravates your primary complaint(s)? ____

Are your symptoms?" ☐ Improving ☐ Unchanging ☐ Worsening ☐ Reoccurring

Previous/Current Treatments

☐ Medication ☐ Massage ☐ Other: ___________________

☐ Injection ☐ Chiropractic

☐ Physical Therapy ☐ Acupuncture

Occupation: ________________________

What is your work status?

☐ Full time ☐ Retired ☐ Other: ___________________

☐ Part time ☐ Unemployed

Due to your primary complaint have you been:

☐ Able to work

☐ Out of work, date started: ______________________________

☐ Returned to work, date range: __________________________

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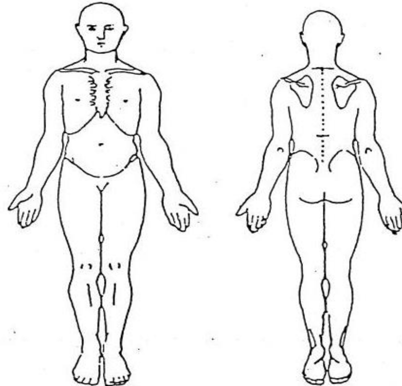
Pain

On the diagram below, please indicate where you are currently have pain:



Using the pain scale below, please choose one number that best answers the following three questions:

PAIN SCALE:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

a. What is your pain level AT ITS WORST? ____________

b. What is your pain level RIGHT NOW? ____________

c. What is your pain level AT ITS BEST? ____________

How would you describe your pain?

☐ Burning ☐ Shooting ☐ Other: ___________

☐ Sharp ☐ Numbness/Tingling

☐ Dull/Achey ☐ Constant

☐ Throbbing ☐ Intermittent

What is the frequency of your pain?

☐ Constant ☐ Occasional ☐ Other: ___________

☐ Intermittent/Daily ☐ Sporadic

Diagnostic Testing/Imaging

☐ X-ray ☐ Cardiac Stress Test ☐ CT Scan

☐ MRI ☐ Doppler Studies ☐ Ultrasound

☐ Nerve conduction/EMG ☐ Bone Scan ☐ Other: ___________

Results: ________________________

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Medical/Surgery

Describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No If yes, how often? ___________________

Please check any of the following that apply to you:

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Bladder conditions
☐ Bowel conditions
☐ Cancer
☐ Cardiac Conditions
☐ Cardiac Pacemaker
☐ Chemical Dependency
☐ Cholesterol Conditions
☐ Circulation Problems
☐ Currently Pregnant
☐ Depression
☐ Diabetes Type 1
☐ Diabetes Type 2
☐ Dizzy Spells
☐ Dysmenorrhea
☐ Eating Disorders
☐ Emphysema/Bronchitis
☐ Endometriosis
☐ Fibroids
☐ Food Sensitivities
☐ Fractures
☐ Gallbladder Problems
☐ Hepatitis
☐ High Blood Pressure
☐ Incontinence
☐ Kidney Problems
☐ Menopause
☐ Metal Implants
☐ Motorized Accidents
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Parkinson's Disease
☐ Prostate Conditions
☐ Recent Fever
☐ Rheumatoid Arthritis
☐ Seizures
☐ Straining with Urination
☐ Strokes
☐ Thyroid Disease
☐ Urgency with Urination
☐ Vulvodynia
☐ Vestibular Conditions
☐ Vision Problems
☐ Recent Weight Loss/Gain
☐ Surgery ______________
____
____

If you indicated "Yes" on any of the above, or if you have any other medical conditions not listed above, please describe in further detail, including any precautions:

____
____
____

Medications/Supplements

Med/Supplement: ______________________________ Dosage: ___________________
Med/Supplement: ______________________________ Dosage: ___________________
Med/Supplement: ______________________________ Dosage: ___________________
Med/Supplement: ______________________________ Dosage: ___________________
Med/Supplement: ______________________________ Dosage: ___________________

This information is truthful and accurate regarding my medical condition.

Patient Signature: ____________________________________ Date: _____________________