PT360 PHYSICAL THERAPY
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Patient Health History

Patient Information

Date ______________________________

Patient Name ______________________________

Date of Birth ______________________________

Patient Occupation ______________________________

When did the Pain start? ______________________________
(Approximate Date)

Describe your pain/problem:

____

____

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other ______________

What activities make the pain worse?

- ☐ Exercise (during)
- ☐ Exercise (after)
- ☐ Sitting
- ☐ Walking
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing/Sneezing
- ☐ Other ______________

What reduces the pain?

- ☐ Lying down
- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Pain Pills
- ☐ Injection for pain
- ☐ Muscles relaxants
- ☐ Nothing
- ☐ Other ______________

Have you had any of these diagnostic tests?

Test			
X-Rays	☐ Yes	☐ No	Date ______________
CT Scans	☐ Yes	☐ No	Date ______________
EMG/NCV	☐ Yes	☐ No	Date ______________
MRI	☐ Yes	☐ No	Date ______________
Arthrogram	☐ Yes	☐ No	Date ______________
Injections	☐ Yes	☐ No	Date ______________

Have you been hospitalized for your problem?

Yes/No (circle one) Date ______________

Have you had surgery for your problem?

Yes/No (circle one) Date ______________

Have you had any other surgeries performed?

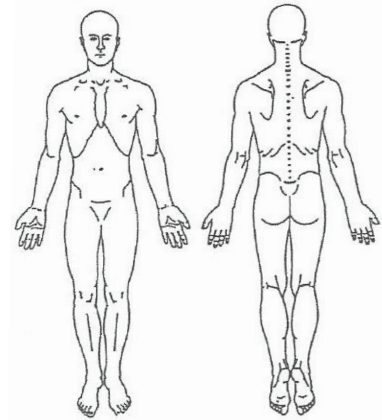
Yes/No (circle one) Date ______________

(Please use reverse side if necessary)

Pain/Symptoms

On the body diagram to the right, indicate your region of pain using the symbols below:

(X) Sharp
(+) Numb/Tingling
(#) Dull/Aching
(B) Burning



Pain Level

0....1....2....3....4....5....6....7....8....9....10

Please list all prescription medications you are taking

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Yes	No	
☐	☐	Allergies
☐	☐	Diabetes
☐	☐	High Blood Pressure
☐	☐	Heart Disease
☐	☐	Stroke (CVA)
☐	☐	Cancer or tumors
☐	☐	Lung Problems
☐	☐	Arthritis/Joint difficulties
☐	☐	(Ir)regular headaches
☐	☐	Dizziness-blackouts
☐	☐	Seizures-nerve disorder
☐	☐	Visual Problems
☐	☐	Menstrual Problems
☐	☐	Immunity disorders
☐	☐	Gout

Yes	No	
☐	☐	Are you pregnant?
☐	☐	Joint replacement
☐	☐	Night sleep disturbance
☐	☐	Change in bowel or bladder habits
☐	☐	Increased hunger/thirst
☐	☐	Indigestion or heartburn
☐	☐	Nausea or vomiting
☐	☐	Changes in memory
☐	☐	Unusual fatigue/weakness
☐	☐	Fever or chills
☐	☐	Frequent or easy bruising or bleeding
☐	☐	Frequent cramping
☐	☐	Do you have pain 24 hours?
☐	☐	Do you awaken from pain?

What other types of doctor/ health care providers have you seen for this condition?

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