



**OUTPATIENT PHYSICAL THERAPY HISTORY FORM**

DATE: \_\_\_\_\_

**SOCIAL HISTORY:**

Date of birth: \_\_\_\_\_ Age \_\_\_\_\_ Circle one: Male/ Female Occupation: \_\_\_\_\_  
If retired please indicate former occupation \_\_\_\_\_  
Leisure Activities/Sports and frequency played \_\_\_\_\_

Tobacco: packs per day: present \_\_\_\_\_ past \_\_\_\_\_ .  
Alcohol consumption: \_\_\_\_\_ drinks per day/week/month (circle one)

**HISTORY OF PRESENT ILLNESS:**

What problem brings you to Physical Therapy today? \_\_\_\_\_

When did this problem begin? (specific date if known) \_\_\_\_\_

Did this problem begin gradually or suddenly? Please describe. \_\_\_\_\_

Have you had surgery for this condition? No \_\_\_ Yes \_\_\_\_.

If you have had surgery please indicate Date \_\_\_\_\_ Type of surgery \_\_\_\_\_

Facility where you had surgery \_\_\_\_\_ Name of surgeon \_\_\_\_\_

Since this problem began your symptoms have :  improved  worsened  stayed the same.

**Please describe** \_\_\_\_\_

How does this problem effect your functional ability at home and at work? \_\_\_\_\_

How does this problem effect your recreation and/or leisure activities? \_\_\_\_\_

Grade your pain level: at rest: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
Painfree Most Pain

With movement: 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10  
Painfree Most Pain

Where is your pain? \_\_\_\_\_

Describe your pain  sharp  dull  throbbing  shooting  burning  tingling  numbness  other \_\_\_\_\_

How often do you have pain?

constant 76-100% of the time  frequent 51-75%  occasional 26-50%  intermittent less than 25%



What diagnostic tests/procedures have you undergone for this problem? (i.e., x-rays, EKG, MRI, CT scan).  
Please list dates and results. \_\_\_\_\_

Have you received treatment for this condition in the past? \_\_\_\_\_

If yes, please indicate type and date of treatment.  PT  OT  chiropractic  MD

Other \_\_\_\_\_

Dates of treatment \_\_\_\_\_

Are you taking any medications for this condition? \_\_\_\_\_ If yes, please list them \_\_\_\_\_

Please list any other medications you are taking \_\_\_\_\_

**PAST MEDICAL HISTORY**

PAST	PRESENT	Condition	PAST	PRESENT	Condition
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart condition
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Migraines/ Headache
<input type="checkbox"/>	<input type="checkbox"/>	Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	Are you presently pregnant?		yes no n/a

Location: \_\_\_\_\_

List any allergies \_\_\_\_\_

Other Medical Conditions not noted above (i.e., surgeries, previous injuries, etc.): \_\_\_\_\_

**PATIENT'S GOALS FOR PHYSICAL THERAPY:**

What do you hope to accomplish by attending physical therapy? \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Representative \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

For therapist use only  smoking cessation advice/ second hand smoke information given to patient

Above report reviewed for accuracy with patient.