ATTA REHAB

Physical Therapy History Form

Name: _____ Date: _____ DOB:_____Height: _____Weight: _____

Primary Complaint: _____

When did your symptoms start: _____ Cause: _____

Why type of medical help have you received for your injury? ☐ MD ☐ Chiropractor ☐ PT ☐ Massage

Have you had an x-ray or MRI for your injury? ☐ Yes ☐ No If yes, when/results_____

Have you had any loss of sensation with your current problem? _____

Are you having difficulty sleeping? _____

Have you suffered from this problem before? ☐ Yes ☐ No If yes, how long ago? _____

Do you have pain, numbness, weakness, or tingling related to your current problem? ☐ Yes ☐ No

If Yes, please continue with questionnaire. If No, please stop here and continue on other side

Where is the pain? (Mark body diagram using the key to describe the location and nature of your symptoms)

Are your symptoms getting better or worse? _____

Describe you pain/symptoms: (Check if all that apply)

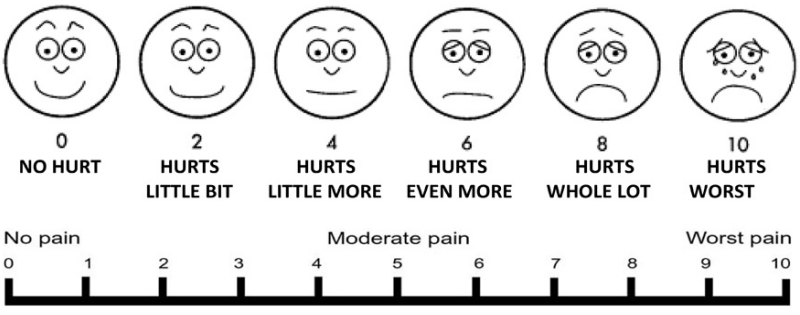
☐ Sharp	☐ Shooting	☐ Burning
☐ Deep Ache	☐ Numbness	☐ Tingling
☐ Weakness	☐ Heaviness	☐ Throbbing
☐ Constant	☐ Comes and goes	

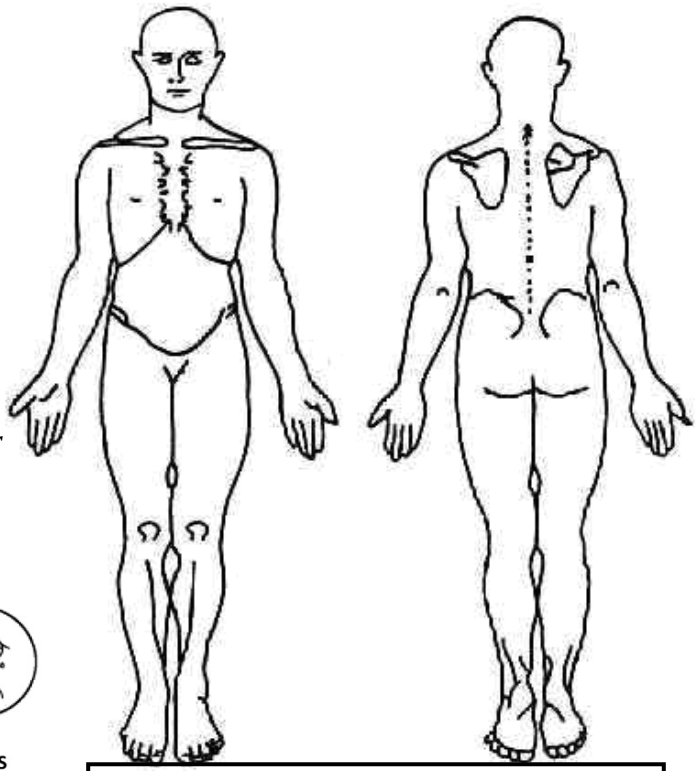
What activities increase your symptoms: _____

_____

What activities do you have difficulty performing due to your Symptoms? _____

Please rate your pain/comfort level using the scale below





X= Pain N=Numbness T=Tingling

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Medical History (Pertaining to your visit in our clinic)

Are you aware of your diagnosis? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No Internal Stimulator (Brain/Spinal)? ☐ Yes ☐ No

Have you received physical therapy services for this problem in the past? ☐ Yes ☐ No
If yes, explain what type of treatment you received?
_____

Have you had any physical therapy services during this calendar year? ☐ Yes ☐ No

Current Medications? _____

Previous Surgeries? _____

Do you smoke? ☐ Yes ☐ No If yes, how many packs/day? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, average daily intake? _____

Please check any of the following conditions that apply to you either currently or in the past:

☐ High Blood Pressure	☐ Stroke	☐ Diabetes
☐ Fainting	☐ Chest pains	☐ Arthritis
☐ HIV/AIDS	☐ Depression	☐ Kidney Disease
☐ Hepatitis	☐ Tuberculosis	☐ Varicose Veins
☐ Chemical Dependency	☐ Thyroid Problems	☐ COPD
☐ Multiple Sclerosis	☐ Obesity	

Other: _____

Function using the Revised Patient Specific Functional Scale

List and score at least 3 activities that you are unable to perform or have the most difficulty performing due to your pain and symptoms. 0= No difficulty 10=Unable to

1. _____ Score: _____ 2. _____ Score: _____
3. _____ Score: _____ 4. _____ Score: _____