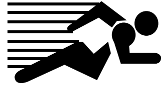
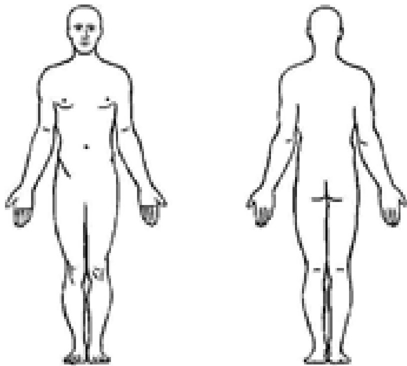


Amelia Physical Therapy Medical History

Patient's Name:________________________**Date**: _____________**Gender**: M F **Age**:______



Height _______ Weight ________

How would you describe your pain? Circle all that apply.

Stabbing	Dull	Shooting	Piercing
Burning	Deep	Superficial	Tingling
Numbness	Sharp	Intermittent	Aching

Please shade in areas of your symptoms on the diagram.

What is your primary reason for today's appointment? _______________________________

Rate pain on a scale of 0-10 (0 ***No Pain*** **and 10** ***Excruciating Pain*****)** ___***Now*** ___***Best*** ___***Worst***

When did the pain start? _________________________

What makes the pain worse?____

What makes the pain better? ____

Did you have surgery regarding this issue? Y N If yes, date: ________Have you had any tests regarding this issue? Xray MRI CT EMG Bone Scan Arthrogram ***List results below:***

____

Are you currently: (please check one) ***Occupation:*** ________________________

__Working at your usual job without restrictions. __Working at your usual job with restrictions.

__ Unable to work because of your condition *Off work since* ______________

__Retired __Unemployed __Student . __Homemaker

<u>Have you EVER been diagnosed as having any of the following conditions? Check all that apply.</u>

__Heart problems	__Circulation problems	__Bladder.urinary tract infection
__High blood pressure	__Asthma	__Kidney problems/infection
__Heart Attack	__Cancer	__Stroke
__Ostoporosis	__Diabetes	__Arthritis
__High cholesterol	__Night Pain	__Depression/Anxiety
__Pacemaker	__COPD	__Other ________________

Please complete the sentence: ***I know I am better if I could*** ______________________________

List current medications on the back of this paper