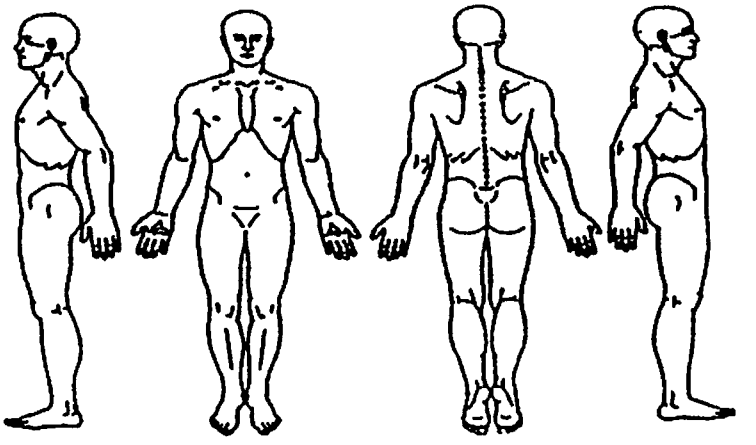
General History

Name: _____ **Date:** _____

Age: _____ **Chief Complaint:** _____

Referring Physician: _____ **PCP:** _____



Pain Scale: 0 _____ 10

Please list all current and past medical conditions:

_____ _____ _____

_____ _____ _____

Please list all medications and dosage:

_____ _____ _____

_____ _____ _____

History of current injury:

Onset Date_____ **(Circle one) Is the problem getting worse, better or the same?**

What makes the pain worse?

_____ _____ _____

What makes the pain better?

_____ _____ _____

Does your discomfort wake you up at night? If yes, please explain how?

_____

_____

_____

What diagnostic tests have you had? (i.e. Xray, MRI, CT Scan)

_____ _____ _____

_____ _____ _____

(Circle one) Is your stress level mild, moderate or severe?

Have you had any surgery in your lifetime?

_____

_____

_____

Is there anyhting else you would like to share about this or any other problem?

_____

_____

What are your goals for physical therapy?

_____ _____ _____

For Office Use Only

◯ Left Arm ◯ Right Arm

Blood Pressure: _____ _____

◯ Sitting ◯ Supine

Pulse: _____ Height: _____ Weight: _____