Patient Name: **Date:**
DOB: **SOS Physical Therapy**

MEDICAL HISTORY

☐ Anemia	☐ Pacemaker	☐ Allergies
☐ Back Pain	☐ Angina	☐ Asthma
☐ Bronchitis	☐ Blood clot	☐ Bladder issues
☐ Drink Alcohol	☐ Heart disease	☐ Dizziness
☐ Gout	☐ Emphysema	☐ Epilepsy/Seizures
☐ Hernia	☐ Hearing difficulties	☐ Heart Attack
☐ Parkinson's	☐ High blood pressure	☐ Kidney disease
☐ Severe/frequent headaches	☐ Pneumonia	☐ Pregnant
☐ Stroke/ TA	☐ Sleeping Problems	☐ Smoke cigarettes
☐ Vision difficulties	☐ Thyroid problem	☐ Varicose veins
☐ Women's health issues	☐ Weakness	☐ Weight/energy loss

Do you have any of the following? (Specify body part & right/left side)

☐ Joint Replacement -

☐ Pins or Metal implant -

☐ Arthritis -

☐ Numbness/tingling/neuropathy -

How often do you normally exercise?

☐ Never

☐ Once per week

☐ Twice per week

☐ 3 times per week

☐ 4 or more times per week

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CHECK ALL THAT APPLY –

- ☐ Complex regional pain syndrome
- ☐ Cancer
- ☐ Diabetes, type 2
- ☐ Diabetes, type 1
- ☐ I have received PT at home
- ☐ I am a caregiver for someone
- ☐ I use a cane/walker
- ☐ I live alone
- ☐ I use a wheel chair
- ☐ Incontinence
- ☐ Infectious disease
- ☐ My home has stairs
- ☐ Other important issues
- ☐ Other surgery
- ☐ Pelvic floor
- ☐ Vertigo/Balance

Does your daily routine, or work, aggravate your injury?

- ☐ No
- ☐ I am unable to participate in my normal routines or work
- ☐ My routine/work impacts my injury 1 day per week
- ☐ My routine/work aggravates my injury 2 days per week
- ☐ My routine/work aggravates my injury 3 or more days per week
- ☐ My routine/work aggravates my injury every day, but I try to cope

Is this a reoccurrence of a prior injury? – Yes No
If Yes, what year? –

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Circle what type of pain you feel from this injury:

Aching	Heavy
Burning	Numb
Constant	Pins & Needles
Cramping	Stabbing
Deep	Throbbing
Dull	Variable
Weak	

What makes your pain worse? (Circle)

Reaching back	Twisting
Laying flat	Lifting anything
Getting out of bed	Lifting heavy weights
Dressing/Grooming	Pulling
Cooking	Raising arm over head
Carrying items	Looking up/down
Climbing stairs	Walking

What helps relieves your pain? (Circle)

Ice	Pain Medication
Heat	Lying flat
Stretching	Avoiding activity
Exercise	Nothing

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Pain Scale: Rate your pain 0 – 10 *(0 being no pain, 10 being worst pain you've ever felt)*

Pain level when your injury first occurred? _____.

Pain level when you are feeling your worst? _____.

Pain level when you are feeling your best? _____.

Please list Medications:
(If you have a list of your medications ready, please give to front desk and they will scan into your chart)

****Include dosage & frequency**** (example: 1 pill swallowed 2x day)

-
-
-
-
-
-

***Vitals required*:**

Height- _____ft _____in

Weight- _____lbs

Falls:
How many times have you fallen in the last year? _____.

Were you injured from a fall? (circle) **Yes** **No**

Would you like automated reminders about your appointments?

Yes – Call, Phone#:

Yes – Text, Cell#:

No