Central Mountain PT- Patient History Questionaire

Pat	Patient Name:	Date:								
1.	Describe your symptoms									
When did your symptoms start?										
	How did your symptoms begin?									
2.	2. How often do you experience your symptoms? ① Constantly (76-100% of the day) ② Frequently (51-75% of the day) ③ Occasionally (26-50% of the day) ④ Intermittently (0-25% of the day)	Indicate where you have pain or other symptoms								
3.	3. What describes the nature of your symptom ① Sharp ④ Shooting ② Dull ache ⑤ Burning ③ Numb ⑥ Tingling									
4.	 4. How are your symptoms changing? ① Getting better ② Not changing ③ Getting worse 									
5.		Please place a check next to the word(s) that best describe your symptoms: Muscle Soreness Stiffness Other: Doesn't Apply								
	What makes your symptoms better?									
	What makes your symptoms worse?	What makes your symptoms worse?								
	At the present time would you say your health is? Excellent Very Good Fair Poor (If the beneficiary is unable to respond, indicate why?)									
6.	Where do you currently reside and do you need additional assistance in your home environment to manage your current diagnosis/limitations?									
7.	. Do you expect any changes to your current living environment (and/or help needed) once you have been discharged from out-patient Physical Therapy:									
8.	8. On the scale below, please circle the number when (None=0) 0 1 2 3 4 5 6	nich best represents your pain level at rest: (Unbearable=10) 7 8 9 10								
9.	9. Please circle the number below which best representations (None =0) 0 1 2 3 4 5 6	esents your pain level with activity: (Unbearable= 10) 7 8 9 10								
10. Who have you seen for your current symptoms in the past year?										
	No one Family MD Orthopedic Surgeon Physical Therapist Chiropractor Other									

11. What tests h	ave you had for	your symptoms	(check all that a	pply)?			
None	X-rays	MRI CT	scan Other:				
12. What is your	occupation? _		Are you:	Full time	Part Time	Off Wo	rk
13. Self Employe	ed? Yes No						
Any Current (Please List)	Work Limitation	s? (Light duty a	nd/or physician	ordered lin	nitations):	No Yes	S
14. Past Medical	History: Please	check each con	dition that you h	nave been t	old you hav	/e:	
Diabetes	Asthma	Lung Disease			na/Chest Pain		
Stroke		Heart Disease	Pacemaker	High	Blood Pressu	ıre	
Cancer Depression	Osteoporosis Anxiety	Arthritis	Other:				
HEIGHT:	WEIG	<u> </u>					
16. Please list (*' you are taking:	*or provide a co	py**) of prescrip	tion medications	s and/or ov	er the coun	ter meds	s
17. What are you	ır goals in comir	ng for treatment?	?				
18. List any Alle	rgies:						
19. Are you aller	gic to Latex?	No Yes					
20. Have you fall	en in the Past Y	ear? No	Yes How many	times:			
21. Do you use a	n assistive devi	ce? No Y	es What type: _				
22. Who is your	referring Doctor	?	Family Do	octor?			
23. When is you	r next Doctor ap	pointment (with	referring doctor)?			
Patient Signatur	e:		Today's	Date:			