

Southern Oregon Physical Therapy Associates, Inc.

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PATIENT HEALTH HISTORY

Name			Date	
Date of Birth	Age	Height	Weight	
Referring Physician	Have you seen any of	her physicians for the	is condition?	
Do you have cancer? ☐ yes ☐ no D	o you have a pacemake	r/electronic stimula	tor/other electronic devi	ce? □ yes □ no
Are you pregnant? ☐ yes ☐ no A	Are you working? If yes,	□ regular duty □ I	light duty Occupation	
What type of injury is this? ☐ motor ☐ Other			FOR PHYSICAL THER	APIST'S USE ONLY
What are your present symptoms? _				
When did they start? (approximate of				
How did they start?				
Have you had any other physical th				
If Yes, Who & When				
Was the onset ☐ Acute Trauma	☐ Repetitive/Overuse	☐ Gradual?		
Have you had <u>similar</u> symptoms in t	he past? □ yes □ no			
Are your symptoms getting \square wo	orse or □ better?			
As the day progresses, do your sym	ptoms:			
☐ Increase ☐ Decrease ☐ Sta	y the same?			
Does pain wake you up at night?]yes □ no			
Isitworsewhenyouare: □ lyin	g still 🛭 changing posi	tions?		
Do you have pain or stiffness when	getting out of bed in the r	morning?		
□ yes □ no				
What kind of pillow do you sleep on	?			
□ soft/flat □ medium □ full	□ contour □ othe	r		
What kind of mattress do you sleep	on?			
□ soft □ medium □ firm	□ futon □ other			
What position do you sleep on at niç	ght?			
□ stomach □ back □ side	☐ side, leaning towa	ard stomach		
☐ side, leaning toward back ☐ c	other			

Health History-2

Since this condition began , have yo	u had difficulties with any of the				
following?					
□ control of bowels	☐ nightsweats				
☐ control of bladder	☐ droppingthings				
☐ fever or chills	☐ tripping				
□ numbness	□ body aches				
☐ dizzinessorfainting	☐ problems with vision				
□ weakness	☐ problems with hearing				
☐ weight change	weight change				
Does this condition prevent you from	n doing any of your daily activities?				
What <u>aggravates</u> your symptoms?					
□ sitting	☐ standing				
\square rising from sitting position	□ squatting				
☐ lying down	☐ sustained bending				
□ walking	□ coughing				
☐ going up or down stairs	☐ sneezing				
□ reaching	☐ taking a deep breath				
□ pulling	☐ chewingoryawning				
☐ driving (☐ manual ☐ autom	natic)				
□ repetitive activities such as					
□ householdchoressuchas					
What <u>relieves</u> your symptoms?					
□ sitting	☐ standing				
□ heat	□ walking				
□ cold	□ exercise				
□ stretching	☐ lying down				
□ wearing a splint	□ massage				
□ rest	☐ medication				
□ other					
Which tests have you had for this co	ndition?				
☐ X-ray	☐ CT Scan				
□MRI	☐ Myelogram				
□ EMG	□ other				
Where did you have them done:					

lave you had any of the following treat	ments for this condition?
□ medication	☐ hypnosis
☐ joint manipulation	☐ biofeedback
□ exercise	☐ TENS unit
☐ massage therapy	□ acupuncture
☐ traction	☐ bedrest
□ braces or splints	☐ hospitalization
□ injections into spine	☐ physicaltherapy
☐ injections into skin or muscles	□ none
□ other	
Medication	
Please check any of the following you	are currently taking:
□ blood pressure	☐ anti-inflammatory
□ cholesterol	☐ sleeping aids
□ pain	☐ antidepressants
☐ muscle relaxer	☐ vitamins
□ insulin	☐ minerals
☐ diabetes medication	☐ antihistamines
☐ heartmedication	□ other
Past Medical History	
Have you ever been diagnosed with a	
□ cancer(type):	
□ depression	☐ rheumatoid arthritis
□ stroke	☐ head injury
☐ heartproblems	☐ stomach problems
☐ high blood pressure	☐ Parkinson's disease
☐ highcholesterol	□ lungproblems
□ kidneyproblems	☐ blooddisorders
☐ thyroid	□ HIV
☐ multiple sclerosis	□ epilepsy/seizures
□ arthritis	□ osteoporosis
□ lupus	☐ circulation/vascular problems
□ brokenbone(s)	☐ tuberculosis
□ hepatitis	□ other
- -····	<u></u>
☐ Allergies (please list)	

Please list	any <u>surge</u>	ries and	I the year	r they w	ere pe	rtormed:		
Surgery						Date		
General He	ealth							
How would	you rate y	our heal	lth befor	e this co	ondition	า?		
□ exceller								
0 11								
On the sca	le below, p	olease in	dicate yo	our pain	level	in the las	t 48 hours	S: •
1 2 No Pain	3	4	5	6	7		9 ain Imagi	10 nable
Percent of	time Pain	Experie	nced: □()-25% □	26-50	0% □51-7	75% □76-	100%
l la aftan	da a	0		-:				
How often of the base of the	-			_			rwook	
What exerc	sise(s) do y	you do?						
Do you drin								
□ yes	_cups pe	rday ∐	no					
Do you sm □ yes		s per dav	⁄ □ no					
What is you								
			h □ Ext	remely	high			

Please mark the diagrams below showing the location and severity of your pain using the following symbols:

N Numb, no feeling T Tingly M Mild Pain X Moderate Pain S Severe Pain! Shooting Pain

