

ADULT PATIENT HISTORY

Name: _____ **DOB:** _____

Date: _____

By filling out this confidential form, you will provide your therapist with pertinent medical information needed to understand your current and past medical conditions. Please provide dates, if known.

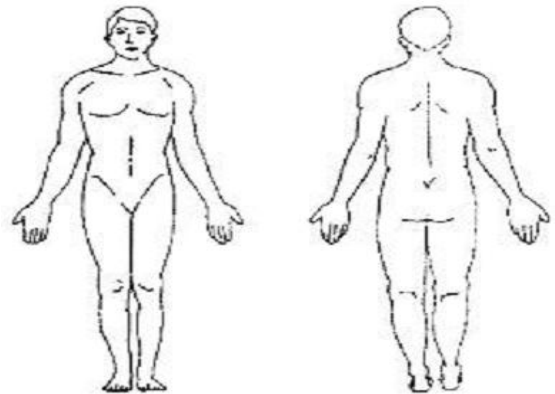
Reason for visit: _____

Date of Onset: _____

Location of Symptoms:

Please mark area(s) of symptoms with an 'X'

Please circle primary area of symptoms.



Level of Symptoms

Please circle your current level of pain or symptoms

No Pain 0 1 2 3 4 5 6 7 8 9 Extreme Pain

At your best in the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 Extreme Pain

At your worst in the last week:

No Pain 0 1 2 3 4 5 6 7 8 9 Extreme Pain

Symptoms Increase with: SITTING BENDING/LIFTING STANDING/WALKING STAIRS OTHER

Symptoms Decrease with: HEAT ICE REST MEDS NOTHING OTHER

Previous Treatment and Outcome: _____

Have you ever been diagnosed with any of the following conditions?

- | | | | | | |
|-----|----|----------------------------|-------|----|-----------------------------|
| YES | NO | Heart Problems | YES | NO | Rheumatoid Arthritis |
| YES | NO | Circulation Problems | YES | NO | Other Arthritis |
| YES | NO | High Blood Pressure | YES | NO | Kidney Disease |
| YES | NO | Asthma | YES | NO | Anemia |
| YES | NO | Chemical Dependency | YES | NO | Epilepsy / Seizures |
| YES | NO | Thyroid Problems | YES | NO | Depression |
| YES | NO | Diabetes | YES | NO | Osteoporosis |
| YES | NO | Multiple Sclerosis | YES | NO | Pregnancy(Current/Past 1yr) |
| YES | NO | Stroke | YES | NO | Other: _____ |
| YES | NO | Cancer, if yes: What kind? | _____ | | |

Activities you have difficulty performing due to your condition:

"Patient Centered Goals" will serve as the basis for treatment.

Goals will be revised as needed.

Please fill in the following so the therapist can consider your desires / goals.

The following examples are provided to assist you to answer.

I know I will be better when I can:

Example 1: Walk independently for 15 minutes with no pain.

Example 2: Use my arm to get dressed without pain

Example 3: Lift and carry groceries into the house.

Example 4: Play 18 holes of golf without pain in my back.

Please fill in the lines below, answering, "I know I will be better when I can:

1. _____
2. _____
3. _____
4. _____