### PATIENT HISTORY

**Patient’s Name (First, Middle, Last)**

**Reason for Visit:**

**Referring physician:**

**Date of next appointment:**

**Date of Onset:**

<table>
<thead>
<tr>
<th>Onset/Timing:</th>
<th>Gradual Onset</th>
<th>Sudden Onset</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Prior Episodes:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**How did your pain/problem start?**
- Unknown
- While Lifting
- Car Accident
- A Fall
- Trauma
- Overuse
- Degenerative Process
- Recreation/Sport:
  - Dental Appt
- Other:

**Severity of pain/problem:**
- Improving
- Not Changing
- Worse

**Describe your pain/symptoms:**
- Sharp
- Dull
- Throbbing
- Aching
- Periodic
- Occasional
- Constant
- Painful/Stiff when getting out of bed
- Other:

**Throughout the day, my pain/problem:**
- Increases
- Decreases
- Stays the same

**Wake up at night when:**
- lying still
- changing positions
- lying still and changing positions

**Sleeping Position:**
- Back, sides and stomach
- on right side
- on left side
- on stomach
- on back
- chair/recliner

**Within the past year, have you had any of the following symptoms?** *(check all that apply)*
- Unable to control bowel/bladder
- Fever/Chills
- Numbness of Genitalia
- Numbness
- Dizziness/Fainting
- Unexplained Weakness
- Unexplained change in weight
- Night Pain/Sweats
- Malaise
- Vision Problems
- Hearing Problems
- Other:

**Aggravating Factors (check all that apply):**
- Sitting
- Looking Up Overhead
- Repetitive Activity
- Sustained Bending
- Chewing
- Other:
- Going to/raising from sitting
- Reach Overhead
- Household Activities
- Cough
- Swallowing
- Walking
- Reach In Front
- Sports/Recreation
- Deep Breathing
- Yawning
- Up/Down Stairs
- Reach Behind Back
- Standing
- Sleeping
- Stress
- Lying Down
- Reach Across Body
- Squatting
- Talking
- Other:

**Alleviating Factors (check all that apply):**
- Rest
- Walking
- Other:
- Nothing
- Cold
- Lying Down
- Heat
- Stretching
- Medication
- Sitting
- Exercise
- Wearing a splint/orthotics
- Standing
- Massage

**Pain is:**
- Constant
- Intermittent
- Variable in Intensity
- Activity Dependent

**Current pain:** /10  **Highest pain in past 2 weeks:** /10  **Lowest pain in past 2 weeks:** /10

Please map your areas of discomfort or altered sensation on the body map.

XXX = Pain

000 = Numb/Tingle/Radiating

*** = Weakness

[Body Map Image]
## MEDICAL/SURGICAL HISTORY

- Please check all that apply

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>ADD</td>
</tr>
<tr>
<td>Bleeding Disorder</td>
</tr>
<tr>
<td>Falls</td>
</tr>
<tr>
<td>Lymphedema</td>
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<tr>
<td>Osteoporosis</td>
</tr>
<tr>
<td>AIDS/HIV</td>
</tr>
<tr>
<td>Brain Injury</td>
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<tr>
<td>Fibromyalgia</td>
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<tr>
<td>Neurological Disorder</td>
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<tr>
<td>Peripheral Vascular</td>
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<tr>
<td>Allergies/Hayfever</td>
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<tr>
<td>Cancer</td>
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<tr>
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<td>Neuropathy</td>
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<tr>
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<tr>
<td>Ankyllosing spondylitis</td>
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<tr>
<td>Carpal Tunnel</td>
</tr>
<tr>
<td>Headaches</td>
</tr>
<tr>
<td>Meniere’s Disease</td>
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<tr>
<td>Serious Illness/Injury</td>
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<td>Muscle/Bone Problem</td>
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<td>Obesity</td>
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<tr>
<td>Back Pain</td>
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<tr>
<td>Epilepsy/Seizures</td>
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**Surgery History:** (please list & include dates (mo/year):

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## MEDICATIONS

- Do you take prescription or nonprescription medication?  
  - YES  
  - NO  
- If yes, please list below or attach a list.

<table>
<thead>
<tr>
<th>Prescription</th>
<th>Non-prescription</th>
</tr>
</thead>
</table>

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## ALLERGIES

- Do you have any allergies?  
  - None  
  - Bees  
  - Latex  
  - Perfumes/lotions  
  - Coconut  
  - pine/linden  
- Adhesive/tapes  
- Other (please specify):  

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

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## SOCIAL HISTORY

### Smoking Status:

- Never  
- Former  
- Current Everyday  
- Current Some Day  
- Smoker – Status Unknown

### Employment/Work (job/school):

- Full time  
- Part time  
- Retired  
- Student  
- Unemployed  
- Disability

### Occupation:

### Exercise Level:

- None  
- Occasional  
- Moderate  
- Heavy  

(Please include type of exercise, days/wk, and average # minutes)

### Marital Status:

- Unknown  
- Married  
- Single  
- Divorced  
- Widowed  
- Domestic Partner

### Living Status:

- Alone  
- Live with others

### Pet(s): (please specify)

### Single/Multi-level home/work:

- Single-level home  
- Multi-level home  
- Single-level work  
- Multi-level work

### # of Entry steps:

<table>
<thead>
<tr>
<th>FRONT</th>
<th>Handrail</th>
<th>YES</th>
<th>NO</th>
</tr>
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<tbody>
<tr>
<td>Garage:</td>
<td>Handrail</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Second Floor</td>
<td>Handrail</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>BACK:</td>
<td>Handrail</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Basement:</td>
<td>Handrail</td>
<td>YES</td>
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### Other Issues:

### Do you use any of the following assistive devices/orthotics?

- Cane (single point, quad)  
- Walker (type:____________________)  
- Crutches  
- Manual/Power wheelchair or cart  
- Wrist braces/splints  
- Ankle foot orthosis (AFO)  
- Foot orthotics (how old? _____)

### Work Related Injury:

- Yes  
- No  

### Auto Related Injury:

- Yes  
- No

### Able to care for self:

- Yes  
- No  

### Home Therapy: Are you currently receiving health care services in your home that are billed to your insurance?  

- Yes  
- No

---

Please rate these activities on a scale 0-10 (0=can perform easily and 10 =cannot do at all) because of your problem.

1. Sleep through night ___  
2. Self care ___  
3. Sit ___  
4. Stand ___  
5. Walk ___  
6. Ascend/descend stairs ___  
7. Lift ___  
8. Reach ___  
9. Work tasks ___  
10. Other: ________________  
11. Other: ________________  
12. Other: ________________

---

**Patient signature:**

**Date:**

**Therapist Signature:**

**Date:**