Gary Krasilovsky, PT, PhD, SST
Schroth Physical Therapist
10 Lookout Lane
Westport, CT. 06880
203-451-3643
email: PTProfessor@gmail.com

Patient Health History Form

(Please complete this form and bring to your first appointment)

Today's Date: _____

Name _____ Date of Birth _____ Age _____

Address: _____

Phone: _____ Email: _____

Emergency Contact (if under 18): Name _____Relationship _____ Phone _____

Referring Physician _____ Primary Physician _____

Insurance: _____ Do you have Medicare? _____

Current Chief Complaint or Functional Limitation:

_____

_____

When did this problem begin? _____

Interventions for this problem thus far? (any therapy, etc?)

_____

_____

Medical evaluations (x-rays; MRI's)? Do you have pictures (digital or printed)?

_____

_____

What physical activity do you do regularly? _____

_____

_____

What is (are) your GOAL(s) for therapy? What would you like for me to be able to help you do?

_____

_____

Current meds, vitamins and/or supplements you are taking, or are prescribed to take:

Name of Product	Prescription or OTC	Dosage Amount and frequency	Reason for medication	complaint?

ALLERGIES TO MEDICATIONS

Name of medication or ingredient	Type of Reaction?

Past Medical History (diagnoses, and approximate date diagnosed)

Diagnosis	Date Diagnosed (or approximate)

Comments: _____

_____

Past Surgical History

Surgery, (including Right or Left, if appropriate)	Date	Surgeon/Location	Any complications?

Comments: _____

_____

Regarding your Spine:

Cobb angles and location if known: Cervical _____; Thoracic _____; Lumbar: _____

Thoracic Kyphosis angle (side view), if known _____

Lumbar Lordosis angle (side view), if known _____

What bothers you most about your posture? _____

_____

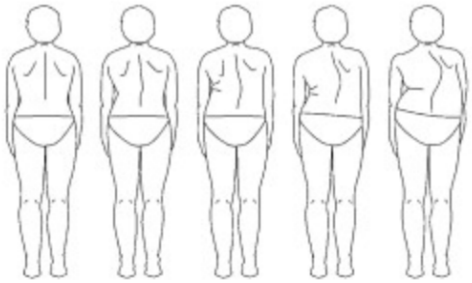
Risser score, if known _____

Year or age of start of menstruation if applicable: _____

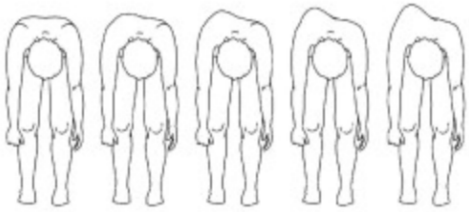
History of Bracing:

Date (from when to when?)	Type or name of brace	#hours/day told to wear	Level of compliance (Always, Most, Some, or Not a Chance)

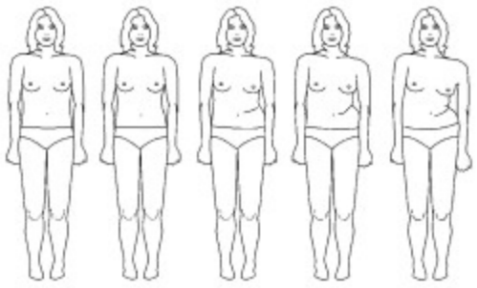
Please circle the images below as to how you feel it most accurately resembles your current physical presentation. For set 3, you only need to circle respective to your gender.



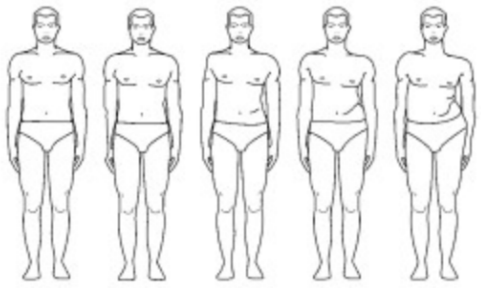
SET 1



SET 2



SET 3 (females)



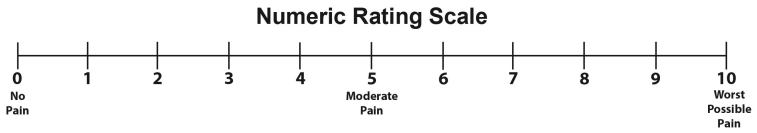
SET 3 (males)

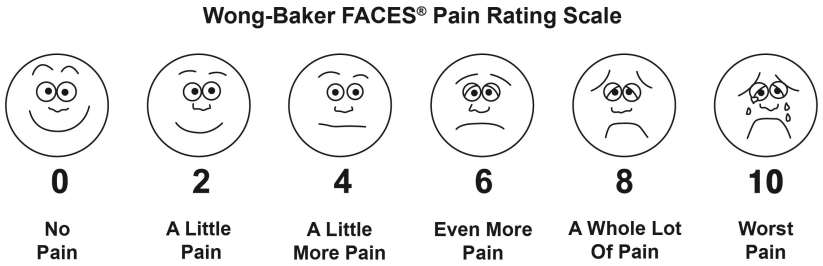
Do you have pain? No ___ (you are finished) Yes _____ (complete below)

- Do you have any pain associated with the current problem? _____
- Does the pain radiate or refer to other areas? _____ If so, where and when? _____

_____

- Please mark on the diagram below the location and type of pain.
- Does pain wake you in the middle of the night? _____
- Does pain limit your ability to get comfortable in bed? (different than above question) _____
- What makes the pain better? _____
- What makes the pain worse? _____





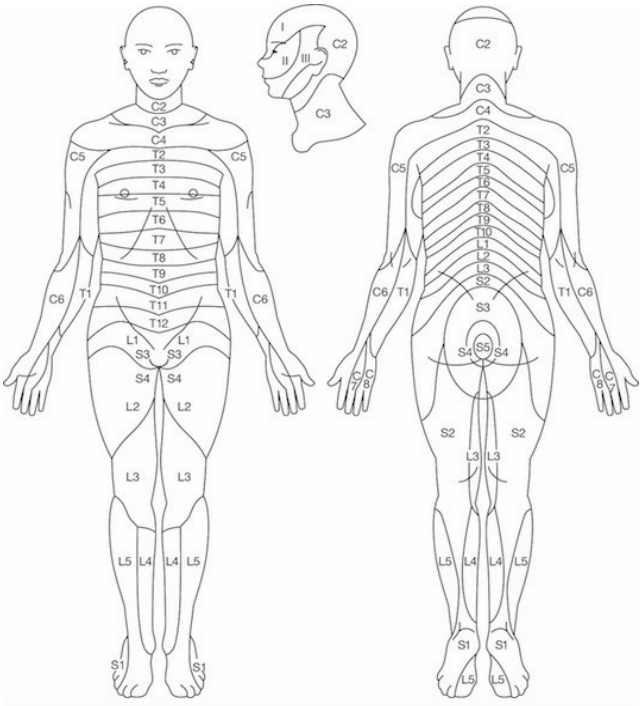
- How would you rate the pain on a scale of 1-10? (You can include a range - best to worst)
- What is your goal for pain relief considering the above scale? _____

Please denote pain or abnormal sensation on the image to the right.

x = pain
☆ = numbness
T = tingling/pins & needles

Please circle pain description:

stabbing
throbbing
dull
achy
sharp
shooting/radiating
pulling



Supplied by Grünenthal Ltd.

Thank you for taking the time to share this essential information!