GAMBRILL'S
PHYSICAL THERAPY

Patient Name:_____

HISTORY FORM

CURRENT CONDITION/CHIEF COMPLAINT

Describe why you are seeking physical therapy? _____

_____

_____

When did it begin? _____

Was there an injury? _____

How is the problem affecting your life? _____

_____

What aggravates your symptoms? _____

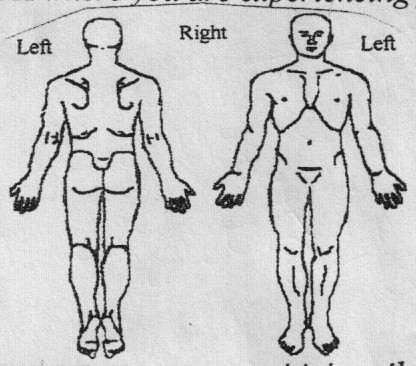
How do you relieve your symptoms? _____

What are your functional goals with therapy? _____

PAIN QUESTIONAIRE

Where is your pain?_____

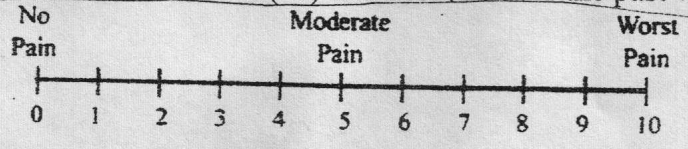
Mark an X where you are experiencing your pain.

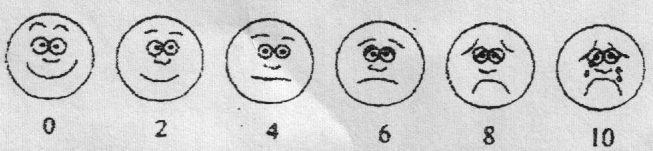


Circle the words how you would describe your pain:

Dull	Throbbing	Shock-like	Pulling
Ache	Sore	Stabbing	Piercing
Sharp	Burning	Tender	_____
Shooting	Heaviness	Pressure	_____
Lacinating	Gnawing	Cramping	_____

Using the 0-10 scale (0=no pain 10=worst pain imaginable) , please circle the number for your current pain level (C) worst (W) and best (B) over the past week.





What medications/dosage have you taken for pain over the past week?

_____

How often does it hurt? □ Constant □Intermittent □AM □PM □Sometimes

What relieves your pain? □Rest □Ice □Heat □Activity □Medication □_____

What aggravates your pain? □Activity_____ □ Position □Cough □Standing □Sitting□ ___

What other problems are there because of the pain?□Appetite Loss □Change in Activity □Difficulty Thinking □Irritable □Loss of Sleep □Nausea/vomiting □_____

Patient Name: _____

PAST MEDICAL HISTORY

(please check if you have or have had any of the conditions)

□Heart Problems_____	□Chemical Dependency	□Infectious Disease
□Stroke	□Depression	□Skin Disease
□High Blood Pressure	□Anxiety Disorder	□Head Injury
□Kidney Problems	□Multiple Sclerosis	□Peripheral Vascular Disease
□Seizures/Epilepsy	□Parkinson's Disease	□Lymphedema
□Osteoporosis/Osteopenia	□Anemia	□Cancer_____
□Asthma	□Blood Disorder	□Prostate Disease
□Emphysema	□Stomach Ulcers	□High Cholesterol
□Hepatitis	□GERD	□Diabetes_____
□Rheumatoid Arthritis	□Osteoarthritis	□_____

Last MD Physical Examination: _____(Date)

Primary Care MD: _____

Specialist MD: _____

Date PMHX Updated:_____

Date PMHX Updated:_____

Date PMHX Updated:_____

Please list any **MEDICATIONS** including over the counter medications that you are currently taking: □See Copy_____

_____

_____

_____

ALLERGIES:_____

SURGICAL HISTORY Date

_____

_____

_____

CPR

Have your completed an advance directive for DNR (Do not resuscitate) which indicates no cardiopulmonary resuscitation (CPR) if you heart stops or if you stop breathing? □ YES □NO

If answered yes, please provide facility with copy of advanced directives.

SOCIAL/HEALTH HABITS

What is your occupation? _____

How many days a week do you exercise? _____

What type of exercise do you do? _____

Marital Status _____

Home Environment: Home/Apartment ___#Steps to enter ___#Steps to 2nd floor

Are there any religious/cultural beliefs that may affect your care that we should be aware of?

_____

Are you currently seeing anyone else for your condition?

□Acupuncturist □Chiropractor □Massage Therapist □Family Practitioner □Cardiologist □Orthopedist □ Podiatrist □Internist □Neurologist □Rheumatologist □Psychologist □OB/GYN □Pediatrician □ _____

CONTACT INFORMATION

□ I give Gambrill's Physical Therapy permission to email me regarding my physical therapy care as well as upcoming events and newsletters. EMAIL ADDRESS: _____

□ I give Gambrill's Physical Therapy permission to use this phone number for all correspondence. PHONE NUMBER :_____