P	GAMB PHYSICAL	RILL'S
W	PHYSICAL	THERAPY

n	1-4:	+	NI	
r	all	ent	IN	ame:

## **HISTORY FORM**

Describe why yo		CONDITION/CHIEF Coal therapy?		
When did it begin	in?			
Was there an ini	urv?			
How is the problem	lem affecting your li	fe?		
What aggravates	s your symptoms?			
	eve your symptoms?	?		
What are your fu	unctional goals with	therapy?		
	PAIN	QUESTIONAIRE		
Where is your pa	ain?			
, p		e you are experiencing yo	our pain.	
	Left C	Right Left		
		S Com		
		JUNI IN		
	1754	Might Mr		
		-   mg 2mg   mg		
	W	4 1-11-1		
	( )	) (41)	4	
	<b>一</b>	J 5X2		
	Circle the woras	now you would describe y	your pain:	
Dull	Throbbing	Shock-like	Pulling	
Ache	Sore	Stabbing	Piercing	
Sharp	Burning			
Shooting	Heaviness	Pressure		
Lacinating	Gnawing	Cramping		
Using the 0-10 s	scale (0=no pain 10	=worst pain imaginable)	, please circle the number	
for your current	pain level (C) wors	t (W) and best (B) over the	ne past week.	
	No	Moderate	Worst	
	Pain	Pain	Pain	
	0 1 2 3	4 5 6 7 8 9	2 10	
			, 10	
	(a) (a)		(A)	
	(3)(3)	$\left( \begin{array}{c} \overline{\circ} \end{array} \right) \left( \begin{array}{c} $		
	0 2	4 6 0		
What medication	ns/dosage have you t	taken for pain over the pa	st week?	
		paris over the pa	or work.	
How often does	it hurt?   Constant	t	□PM □Sometimes	•
What relieves yo	our pain? Rest Dic	e	Medication $\Box$	
What aggravates	your pain? \( \subseteq Activit	v □ Position □Couc	Th Standing Sitting	
what other prob.	lems are there becau	se of the pain? Annetite	I acc of Change in Activity	
□Difficulty Thin	king □Irritable □I	Loss of Sleep □Nausea/vo	omiting $\square$	

	PAST MEDICAL HI	
(please c	heck 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		
Last MD Physical Examinat		
Service MD:		
Specialist MD:		
Date PMHX Updated:		
Date PMHX Updated:		
Date PMHX Updated:		
		nter medications that you are currently
taking: □See Copy		
<u> </u>		
ALLERGIES:		
SURGICAL HISTORY		Date
CDD		
CPR		
TT 1 1 1	i' i' c Dym (D	
	수 있습니다. 그 사람들은 아이들 마시간 것은 하는 것이 없다면 하면 하는데 하나 아니는데 아이들이 살아 있다. 그는데 아이들은 아이들이 살아 있다면 하는데	not resuscitate) which indicates no
cardiopulmonary resuscitati	on (CPR) if you heart stops	or if you stop breathing?   YES   NO
cardiopulmonary resuscitati	수 있습니다. 그 사람들은 아이들 마시간 것은 하는 것이 없다면 하면 하는데 하나 아니는데 아이들이 살아 있다. 그는데 아이들은 아이들이 살아 있다면 하는데	or if you stop breathing?   YES   NO
cardiopulmonary resuscitati	on (CPR) if you heart stops	or if you stop breathing?   YES   NO
cardiopulmonary resuscitati If answered yes, please prov	on (CPR) if you heart stops	or if you stop breathing?   YES   NO vanced directives.
cardiopulmonary resuscitati	on (CPR) if you heart stops vide facility with copy of adv	or if you stop breathing?   YES   NO vanced directives.
cardiopulmonary resuscitati If answered yes, please prov	on (CPR) if you heart stops wide facility with copy of adv	or if you stop breathing?   YES   NO vanced directives.
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cardiopulmonary resuscitati If answered yes, please prov What is your occupation? How many days a week do What type of exercise do yo Marital Status Home Environment: Home Are there any religious/cult  Are you currently seeing an □Acupuncturist □Chiroprace □Orthopedist □ Podiatrist □Pediatrician □	on (CPR) if you heart stops wide facility with copy of advide facility with copy of advisory of action of the stop of advisory of the stop of action of the stop o	or if you stop breathing?   YES   NO vanced directives.  HABITS  ———————————————————————————————————
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Cardiopulmonary resuscitation of the second	sociality with copy of advide facility with copy of advide social facility with copy of advice	or if you stop breathing?   YES  NO vanced directives.  HABITS  ———————————————————————————————————

Patient Name: \_