# Austin Physical Therapy, PLLC

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## Patient History

**Name** _____ **Age**_____ **Date**_____

1. Describe the current problem that brought you here and how it occurred?_____

_____

2. When did your problem first begin?____months ago or ___ years ago.
Injury/onset date/change of status date _____What caused this? ☐Specific incident(s) describe_____ ☐gradual onset ☐no known cause

3. Did you have surgery for this problem? If so what surgery and provide the date of surgery.

_____

Other surgical history and dates_____

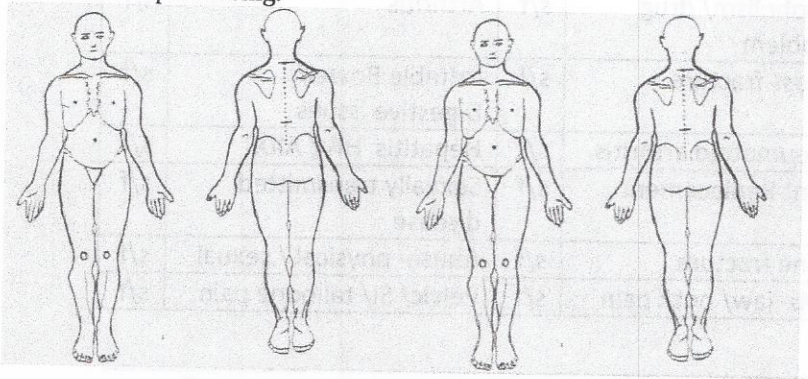
4. Do any of the following make your problem worse? (check all that apply)

☐sitting greater than _____minutes/hours ☐standing greater than _____minutes/hours
☐walking greater than _____distance/minutes ☐stairs-up ☐stairs-down
☐ Changing position (sit to stand, lying down) ☐bending/squatting
☐voiding ☐cough/sneeze/straining/laughing
☐vigorous activity (running, jumping, weights) ☐light activity (light house or yard work
☐cold weather/rain,snow/change ☐with nervousness/anxiety/stress
☐triggers –running water, key in door (pertains to incontinent issues)
☐Sexual activity ☐No activity affects the problem

5. Rate your problem on a scale of 0-10, 10 being the worst (circle or write your descriptor: pain, weakness, disability, dizziness, _____), 0 being no problem, 5 moderate, 10 extreme:

At worst 0---1---2---3---4---5---6---7---8---9---10
Current 0---1---2---3---4---5---6---7---8---9---10
At best 0---1---2---3---4---5---6---7---8---9---10
If describing pain- Location_____

Symptom Description:☐ burning ☐sharp ☐dull/achy ☐throbbing ☐shooting ☐numbness/tingling ☐constant ☐intermittent ☐ worse in AM ☐ worse in PM ☐worse at night ☐other_____
Please indicate where you are experiencing pain on the diagrams below that most accurately reflect the discomfort that you have been experiencing.



Symptoms get better with:_____
Symptoms get worse with:_____
6. Describe previous treatment/practitioners and the effect_____

_____

7. Do you have difficulty getting around your home or community? Specify_____

_____

Social activities (exclude physical activities), specify_____
Physical activity, specify _____
Work, specify _____

**Health History: Have you recently been having any of the following (circle Y for yes and N for no):**

| | | | | |
|---|---|---|---|---|
| | Fever / chills | Y/N | Unexplained tiredness | Y/N |
| B | Unexplained weight change, loss of appetite | Y/N | Unexplained muscle weakness | Y/N |
| C | Dizziness or fainting | Y/N | Night pain/ sweats | Y/N |
| D | Change in bowel or bladder functions | Y/N | Numbness / tingling Y/N | Y/N |
| E | Blood in urine, stool, vomit, mucus | Y/N | confusion, memory loss | Y/N |
| F | swelling or lumps anywhere | Y/N | difficulty breathing, coughing | Y/N |
| G | skin changes, rash, pigmentation, clubbing of fingers, toes | Y/N | falls | Y/N |

Date of Last Physical Exam _____ Tests performed_____
Results/Findings_____
Occupation _____On disability or leave?_____ Activity Restrictions? _____
**Mental Health**: Current level of stress High____ Med___ Low___ Current psych therapy? Y/N
**Activity/Exercise**: None 1-2 days/week 3-4 days/week 5+ days/week
Describe _____

8. Have you, a parent, sibling (brother or sister) ever had any of the following conditions or diagnoses? Circle **S** (for self), **F** (for close family- parent or sibling), and describe below:

| | | | | | | |
|---|---|---|---|---|---|---|
| a | Cancer | S/F | Stroke | S/F | Emphysema/ chronic bronchitis / respiratory | s/f |
| b | Heart problems | S/F | Seizures | s/f | Asthma | s/f |
| c | High Blood Pressure | S/F | Multiple Sclerosis | s/f | Allergies | s/f |
| d | Ankle swelling | S/F | Head injury | s/f | Latex sensitivity | s/f |
| e | Anemia | S/F | Osteoporosis | s/f | Hypo or hyperthyroid | s/f |
| f | Low back pain | S/F | Shoulder pain | s/f | Headaches | s/f |
| g | Sacroiliac/ tailbone pain | S/F | Fibromyalgia/ Chronic Fatigue | s/f | Diabetes- type 1 or 2 | s/f |
| h | Kidney disease | S/F | Alcoholism/ drug problem | s/f | Arthritis | s/f |
| i | bladder problems | S/F | Stress fracture | s/f | Irritable Bowel/ Digestive issues | s/f |
| j | Depression | S/F | Rheumatoid arthritis | s/f | Hepatitis HIV/ AIDS | s/f |
| k | Eating disorder: anorexia, bulimia | S/F | Joint Replacement | s/f | Sexually transmitted disease | s/f |
| l | Smoking | S/F | Bone fracture | s/f | Abuse- physical / sexual | s/f |
| m | Vision/ eye problems | S/F | TMJ- jaw/ neck pain | s/f | Pelvic/ SI/ tailbone pain | s/f |

Other/Describe_____
If you currently smoke tobacco: # packs/day____; drink alcohol: How many days /week on average?_____
Medications - pills, injection, patch Start date Reason for taking
_____
_____
_____
Over the counter -vitamins etc Start date Reason for taking
_____
_____
_____

Patient Signature _____ Date_____