Hope PT
Manual Physical Therapy
Relieving Pain. Restoring Function. Renewing Hope.

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MEDICAL HISTORY

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Gender:** MALE FEMALE **Pregnant:** YES NO

City/State/Zip: _____ **Height:** _____ **(Ft/In)** **Weight:** _____ **(Lbs)**

Telephone: _____ **Occupation/Retired:** _____

Emergency Contact: _____ **Active Hobby(ies):** _____

Active Sport(s): _____

Rate Your General Health (circle one)
Excellent Good Fair Poor

PRESENT Condition and Cause (Mechanism of Injury)

Reason for Your Visit Today: PAIN? DECREASED FUNCTION? SORE/WEAK? STIFF? Other _____

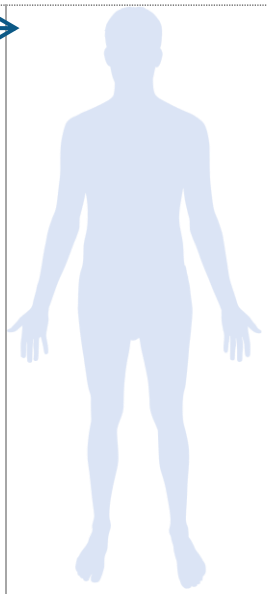
When Did Your Present Symptoms Start? (approx.date) _____ **How?** Gradually Suddenly

What Caused Your Symptoms? (circle one) Work Injury/Accident Auto/Truck Accident Surgery
Physical Condition Fall Chronic Aging Don't Know

Have You Had Previous or Ongoing Physical Therapy For Today's Symptoms? YES NO When? _____

Do you have Home Health Care? Yes No

Pain Location: Mark area(s) on body example where you feel your symptoms:



Current PAIN LEVEL: On a scale of 1 to 10: [0 =NO pain, 10 =WORST pain]:

0 1 2 3 4 5 6 7 8 9 10
NO pain Moderate WORST

Is Your Pain: Constant Intermittent Occasional

List 3 important activities you are **unable to do or have difficulty doing** because of your symptoms:

1) _____
2) _____
3) _____

What Number represents Your **Overall Average Level of Function**:

0 1 2 3 4 5 6 7 8 9 10
CANNOT DO anything **CAN DO anything**

Are you currently experiencing any of the following? (circle all that apply)			
Headache	Poor Balance (Fall/Stumble)	Numbness/Tingling	Shortness of Breath
Depression	Change in Bowel or Bladder Function	Change in Appetite	Difficulty Swallowing
Pelvic Pain	Unexplained Weight Loss	Fever/Chills/Sweats	Nausea/Vomiting
Dizziness	Night Pain	Other _____	

Conditions: Have you ever been told you have:

Alzheimer's	Yes	No
Cardiovascular Disease	Yes	No
Cauda Equina Syndrome	Yes	No
Cerebral Vascular Accident	Yes	No
Current Infection	Yes	No
Diabetes Mellitus Type I	Yes	No
Diabetes Mellitus Type II	Yes	No
Fibromyalgia	Yes	No

Fracture or Suspected Fracture	Yes	No
High Blood Pressure	Yes	No
History of Cancer	Yes	No
Huntington's	Yes	No
Immunosuppression	Yes	No
Lupus	Yes	No
Muscular Dystrophy	Yes	No
Obesity	Yes	No

Osteoarthritis	Yes	No
Osteoporosis	Yes	No
Parkinson's	Yes	No
Rheumatoid Arthritis	Yes	No
Traumatic Brain Injury	Yes	No
Other _____		

Surgery/Procedures/Tests

Type (e.g. Knee Replacement; MRI; X-ray)	When

Current Medications / Supplements (Medicines, Vitamins, Minerals, Other)

Name	Medical Prescription	OTC (Over-The-Counter)
	☐	☐
	☐	☐
	☐	☐

Therapy Goals

What are your personal goals for therapy at this time? _____

_____

CONSENT

CONSENT: My diagnosis and treatment plan will be discussed during my appointment and I understand that I have the right to question and/or refuse any treatment offered.

PATIENT INITIALS _____