PT360
EXCELLENCE IN MOTION

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Today's Date:_____

Medical History

Date of Injury:_____

Primary complaint(s)? _____ Date of onset: _____

Surgery Performed? ☐ Yes ☐ No If Yes, Date/Type of Surgery: _____

Have you been hospitalized for this complaint? ☐ Yes ☐ No If Yes, date range: _____

Is your injury related to a fall? ☐ Yes ☐ No If Yes, date of fall: _____

Symptoms

What are your symptoms related or due to?

☐ Work ☐ Overuse ☐ Other: _____

☐ Auto accident ☐ Trauma

☐ Sports Injury ☐ Chronic

What aggravates your primary complaint(s)? _____

Are your symptoms?" ☐ Improving ☐ Unchanging ☐ Worsening ☐ Reoccurring

Previous/Current Treatments

☐ Medication ☐ Massage ☐ Other: _____

☐ Injection ☐ Chiropractic

☐ Physical Therapy ☐ Acupuncture

Occupation: _____

What is your work status?

☐ Full time ☐ Retired ☐ Other: _____

☐ Part time ☐ Unemployed

Due to your primary complaint have you been:

☐ Able to work

☐ Out of work, date started: _____

☐ Returned to work, date range: _____

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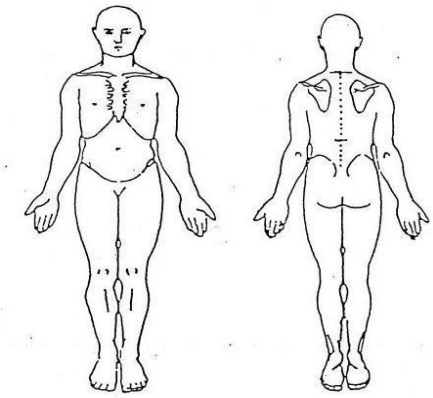
Pain

On the diagram below, please indicate where you are currently have pain:



Using the pain scale below, please choose one number that best answers the following three questions:

PAIN SCALE:

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain)

a. What is your pain level AT ITS WORST? _____

b. What is your pain level RIGHT NOW? _____

c. What is your pain level AT ITS BEST? _____

How would you describe your pain?

☐ Burning ☐ Shooting ☐ Other: _____
☐ Sharp ☐ Numbness/Tingling
☐ Dull/Achey ☐ Constant
☐ Throbbing ☐ Intermittent

What is the frequency of your pain?

☐ Constant ☐ Occasional ☐ Other: _____
☐ Intermittent/Daily ☐ Sporadic

Diagnostic Testing/Imaging

☐ X-ray ☐ Cardiac Stress Test ☐ CT Scan
☐ MRI ☐ Doppler Studies ☐ Ultrasound
☐ Nerve conduction/EMG ☐ Bone Scan ☐ Other: _____

Results: _____

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Medical/Surgery

Describe your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke? ☐ Yes ☐ No If yes, how often? _____

Please check any of the following that apply to you:

☐ Allergies	☐ Dizzy Spells	☐ Osteoporosis
☐ Anemia	☐ Dysmenorrhea	☐ Parkinson's Disease
☐ Anxiety	☐ Eating Disorders	☐ Prostate Conditions
☐ Arthritis	☐ Emphysema/Bronchitis	☐ Recent Fever
☐ Asthma	☐ Endometriosis	☐ Rheumatoid Arthritis
☐ Bladder conditions	☐ Fibroids	☐ Seizures
☐ Bowel conditions	☐ Food Sensitivities	☐ Straining with Urination
☐ Cancer	☐ Fractures	☐ Strokes
☐ Cardiac Conditions	☐ Gallbladder Problems	☐ Thyroid Disease
☐ Cardiac Pacemaker	☐ Hepatitis	☐ Urgency with Urination
☐ Chemical Dependency	☐ High Blood Pressure	☐ Vulvodynia
☐ Cholesterol Conditions	☐ Incontinence	☐ Vestibular Conditions
☐ Circulation Problems	☐ Kidney Problems	☐ Vision Problems
☐ Currently Pregnant	☐ Menopause	☐ Recent Weight Loss/Gain
☐ Depression	☐ Metal Implants	☐ Surgery
☐ Diabetes Type 1	☐ Motorized Accidents	_____
☐ Diabetes Type 2	☐ Multiple Sclerosis	_____

If you indicated "Yes" on any of the above, or if you have any other medical conditions not listed above, please describe in further detail, including any precautions:

_____

_____

_____

Medications/Supplements

Med/Supplement:_____ Dosage:_____

Med/Supplement:_____ Dosage:_____

Med/Supplement:_____ Dosage:_____

Med/Supplement:_____ Dosage: _____

Med/Supplement:_____ Dosage: _____

This information is truthful and accurate regarding my medical condition.

Patient Signature:_____ Date: _____