Physio Pro

A physical therapist owned private practice

Patient History Form

Name (Last, First, MI):_____ Date:_____

Please describe your condition or symptoms:_____

_____

Surgery Date (if applicable): _____Have you missed any work due to your condition? YES NO

Date your condition or symptoms began:_____

Initially seen for this condition on (date): _____by Dr._____

Who referred you to our clinic? _____ Primary Care Physician: _____

May we send your PCP updates on your condition? YES NO

Please rate your pain level: no pain = 0 1 2 3 4 5 6 7 8 9 10 = worst pain

Do you have numbness or tingling? YES NO If yes, where? _____

Prior to onset, were you free of these symptoms? YES NO Explain: _____

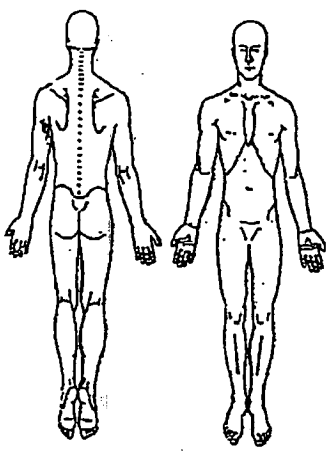
What eases these symptoms? _____

What aggravates these symptoms? _____

Have you had any treatment for this condition? YES NO Did it help? YES NO

What type and where? _____

Have you had X-rays / MRI / Arthrogram? YES NO Findings: _____



On the diagram please draw or depict your pain:

-Please Turn Over-

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Please list any surgeries or injuries (fractures, dislocations, sprains, etc.) for which you have been treated or hospitalized.

Include approximate dates. _____

_____

What are the most important things you hope to accomplish with physical therapy? _____

_____

In order to be in compliance with all **Medicare Requirement**, we need the following information from you:

1. Height:_____ft., _____inches,

2. Weight:_____lbs.

3. A list of current medications including dosage and frequency:

Medication:	**Dosage:**	**Frequency:**
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day
_____,	_____mg.,	_____x per day

Patient Signature: _____ **Date:** _____

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