Print Form

Progressive Physical Therapy

Medical History

INJURY DETAILS

Type of Injury: _____ Date of Onset: _____

How did the injury occur? _____

List any medications you are presently taking (if any): _____

Have you had x-rays taken for this injury? ☐ Yes ☐ No

PAIN DESCRIPTION

Which of the following best describes your pain? (check one) ☐ Sharp ☐ Dull ☐ Aching ☐ Shooting

Which of the following best describes the frequency of your pain? (check one) ☐ Constant ☐ Intermittent ☐ Occasional

What makes your pain feel worse? (check all that apply) ☐ Lifting ☐ Leaning ☐ Dressing ☐ Climbing ☐ Sitting ☐ Walking ☐ Standing ☐ Reaching ☐ Driving ☐ Bending ☐ Stooping ☐ Laying Down

What makes your pain feel better? _____

Please rate the level of pain you have experienced over the past 30 days:	NO PAIN 0	1	2	3	4	MODERATE PAIN 5	6	7	8	9	WORST PAIN 10
What number on the pain scale best describes your pain **right now**?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **worst pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale describes your **least pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○

SYMPTOM DIAGRAM

Using the diagram at right, please indicate the location and type of symptoms you are experiencing. ➲

(Use the symbols from the diagram key to indicate the location and type of symptom on the image.)

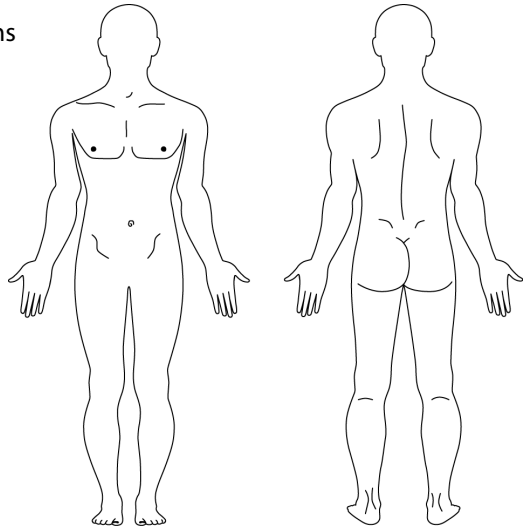

DIAGRAM KEY	
SYMBOL	SYMPTOM
X	pain
.....	numbness
____	tingling

GENERAL MEDICAL HISTORY

Do you have a history of cancer? ..... ☐ Yes ☐ No

Do you have a pacemaker? ..... ☐ Yes ☐ No

Do you have hypertension? ..... ☐ Yes ☐ No

Do you have bowel/bladder problems? ..... ☐ Yes ☐ No

Are you diabetic? ..... ☐ Yes ☐ No

Are you pregnant? ..... ☐ Yes ☐ No

Please list any other relevant past medical or orthopedic history: _____