NOVANT HEALTH

Physical Therapy

Medical History

Patient Name	Date of Birth

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	Moderate Pain 4	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 best describes your **worst pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○
What number on the pain scale best describes your **least pain** over the past 30 days?	○	○	○	○	○	○	○	○	○	○	○

General Medical History

Do you have a history of cancer?	☐ Yes ☐ No
Do you have a pacemaker?	☐ Yes ☐ No
Do you have high blood pressure?	☐ 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.

Symptom Diagram

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

Use the symbols from the diagram key below to indicate the location and type of symptoms.

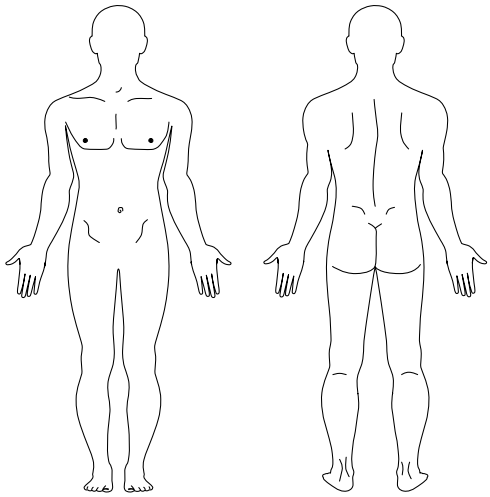

DIAGRAM KEY	
SYMBOL	SYMPTOM
X	pain
- - - - - -	numbness
— — — —	tingling