Peak Physical Therapy

Patient Information

Date: _____

Patient Name: _____ Patient Date of Birth: _____

Patient Occupation: _____ When did the pain start? _____ (*Approximate Date*)

Patient History

How did the pain start?

- ☐ Suddenly
- ☐ Gradually
- ☐ Lifting
- ☐ No apparent reason
- ☐ Pulling
- ☐ Injured at work
- ☐ Bending
- ☐ Other

What activities make the pain worse?

- ☐ Walking
- ☐ Exercise (during)
- ☐ Exercises (after)
- ☐ Sitting
- ☐
- ☐ Sneezing
- ☐ Bending forward
- ☐ Bending backwards
- ☐ Coughing
- ☐ Other

What reduces the pain?

- ☐ Standing
- ☐ Sitting
- ☐ Lying down
- ☐ Walking
- ☐ Anti-inflammatories
- ☐ Muscle relaxants
- ☐ Injection for pain
- ☐ Pain Pills
- ☐ Nothing
- ☐ Other

Is your pain a result of trauma (Fall, MVA)?

☐ Yes ☐ No

How long have you had this pain?

_____Weeks _____ Months _____ Years

Have you had any of these diagnostic tests?

X-rays	☐ Yes	☐ No	Date_____
MRI	☐ Yes	☐ No	Date_____
CT Scan	☐ Yes	☐ No	Date_____
EMG/NCV	☐ Yes	☐ No	Date_____
Arthrogram	☐ Yes	☐ No	Date_____
Injections	☐ Yes	☐ No	Date_____

Have you been hospitalized for your problem?

☐ Yes ☐ No Date_____

Have you had surgery for your problem?

☐ Yes ☐ No Date_____

Have you had any other surgery performed?

☐ Yes ☐ No Date_____

Medical history:

Yes / No

- ☐ ☐ High Blood Pressure
- ☐ ☐ High Cholesterol
- ☐ ☐ Diabetes
- ☐ ☐ Heart Disease
- ☐ ☐ Stroke (CVA)
- ☐ ☐ Cancer or Tumors
- ☐ ☐ Lung problems
- ☐ ☐ Osteoarthritis –(joint)
- ☐ ☐ Osteoporosis – (bone density)
- ☐ ☐ Rheumatoid disorders
- ☐ ☐ Dizziness / blackouts
- ☐ ☐ (Ir)regular headaches
- ☐ ☐ Nerve disorders
- ☐ ☐ Visual problems
- ☐ ☐ Immunity disorders
- ☐ ☐ Gout
- ☐ ☐ Shortness of breath
- ☐ ☐ Fever or chills
- ☐ ☐ Circulation disorders
- ☐ ☐ Joint replacement(s)
- ☐ ☐ Are you pregnant?
- ☐ ☐ Do you smoke?
- ☐ ☐ Have a pacemaker?
- ☐ ☐ Have constant pain
- ☐ ☐ Seizures
- ☐ ☐ Does pain wake you?
- ☐ ☐ Frequent or easy bruising/bleeding
- ☐ ☐ Unusual fatigue-weakness
- ☐ ☐ Nausea or vomiting
- ☐ ☐ Indigestion or heartburn
- ☐ ☐ Frequent urination
- ☐ ☐ Change in stool color/bleeding
- ☐ ☐ Change in bowel or bladder habits
- ☐ OTHER:_____

What Medications are you currently taking? _____

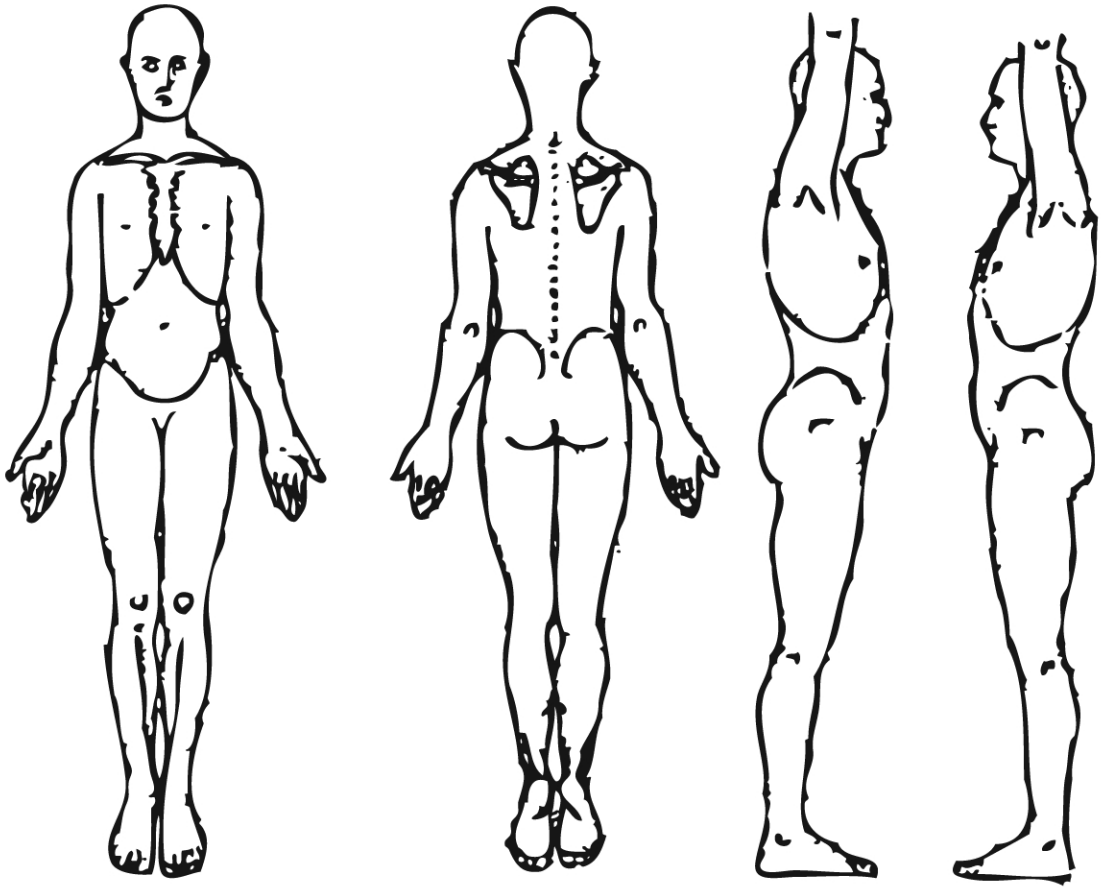
_____

_____

What other types of doctor/health care providers have you seen for this condition? -

_____

Directions: On the body diagram below, please mark the areas of your symptoms as they are at this moment of your evaluation.



Front
Right Left

Back
Left Right

Side
Right

Side
Left

No Pain ——————————— Pain as bad as it could be

On the line above, please mark an (x) on the line
to indicate your level of pain.