

PATIENT HEALTH SUMMARY

Name: _____ Age: _____ M F DOB: _____

Occupation/Student (grade): _____ Hand Dominance: R / L (circle one)

Reason you are being seen today: _____

Have you had any diagnostic testing for your current condition? If so, what tests: _____

Date of injury or when your symptoms began: _____

How were you injured? _____

Describe your current symptoms: _____

What makes your symptoms worse? _____

What makes you feel better? _____

How long can you stand? _____ sit? _____ walk? _____

Have you experienced a fall within the past 12 months? [] Yes [] No If so, were you injured? [] Yes [] No

Do you have a previous history of the condition for which you are being seen today? Yes _____ No _____

What leisure/physical activities do you enjoy? _____

What activities/movements can you no longer do due to your injury? _____

What are your goals for therapy? _____

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes _____ No _____

Medication/Injection and condition taken/given for: _____

Please check all that apply to you:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Prostate Condition |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Hepatitis/kidney problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bowel/bladder |
| <input type="checkbox"/> High BP/hypertension | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Phlebitis/Circulatory Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Migraines/headaches |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Stroke | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dizzy Spells |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Seizure |
| | | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Tobacco use |

Are you currently pregnant? Yes _____ No _____

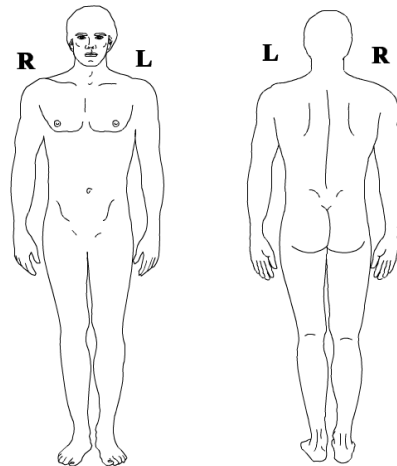
Is there anything else you feel we should be aware of? (fractures, other medical conditions)

List surgeries you've had: _____

Circle the number that best describes your status:

Please shade in the areas where you are experiencing pain:

PAIN 0 1 2 3 4 5 6 7 8 9 10
Best _____ Worst



Please notify your therapist if there are any changes in your condition.
Thank you for coming to our clinic for your therapy needs.

Patient Signature _____

Date _____