PT Onsite

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ptonsite.com

PT ONSITE PLLC
Patient History and Current Symptoms

Welcome to PT Onsite. We are excited to work with you and look forward to helping you to meet your health and wellness goals. Please answer the questions below to the best of your ability. These questions may seem unrelated to your current condition; however often medical history and medications can impact decision making regarding your treatment. If you have concerns about why we need the answer to a particular question, please place an asterisk in the space for the answer and you can discuss with your physical therapist. If you feel there is not enough space for your answer simply answer briefly and circle your answer indicating that you would like to discuss further with your physical therapist.

Name	
Date of Birth	
Name of Primary Care Physician	
Current Medications, Vitamins/Supplements, with Dosages	
What is your occupation?	
Do you do regular exercise – if so what type?	
Do you or have you ever smoked (if yes #/day, # of years, & quit date)?	
Do you drink alcohol?	
Are you or is it possible you are pregnant no?	
For women – have you ever been pregnant (yes # of pregnancies and date)?	
Do you have a pacemaker or internal defibrillator or stimulator?	
Do you have any metal implants in body – if so where and date implanted?	
Any new weight loss or gain and change in energy level	

Allergies – both food and environmental	

Do you now or have you ever had any of the following?

	Yes/Year and description if applicable	No
Cancer, tumor or cyst		
Lung disease – including asthma, emphysema, bronchitis, pulmonary emboli		
Cardiac disease – including murmur, heart attack, stent, bypass, arrhythmia, angina/chest pain		
High Blood Pressure		
Diabetes, or high sugar		
Blood issues including anemia, clotting		
Vascular disease – including varicose veins/phlebitis, DVT, Peripheral vascular disease		
Neurological events including TIA, Stroke and brain injury (concussion), seizure		

	Yes/Year and description if applicable	No
Neurological disease including MS, Parkinson's disease, Epilepsy, Fibromyalgia		
Urinary/bowel issues including kidney disease, incontinence, or IBD		

Do you now or have you ever had any of the following?

	Yes/Year and description if applicable	No
Spine Dysfunction – including sprains, strains, disc and facet issues		
Joint issues and bone issues – including osteoporosis, osteomyelitis, arthritis, hypermobility		
Muscle and tendon issues including, tendonitis, tears, sprains and surgeries		
List history of Surgeries		

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

Primary Care Physician	Yes /approx. date	No
Specialist		
Chiropractor		
Physical or Occupational Therapy		
Massage Therapy		
Emergency Room		
X-rays		
MRI		
CT Scan		
EMG/NCV		

Describe what brought you to PT today:

_____

_____

How does your condition Interfere you're your life and/or work

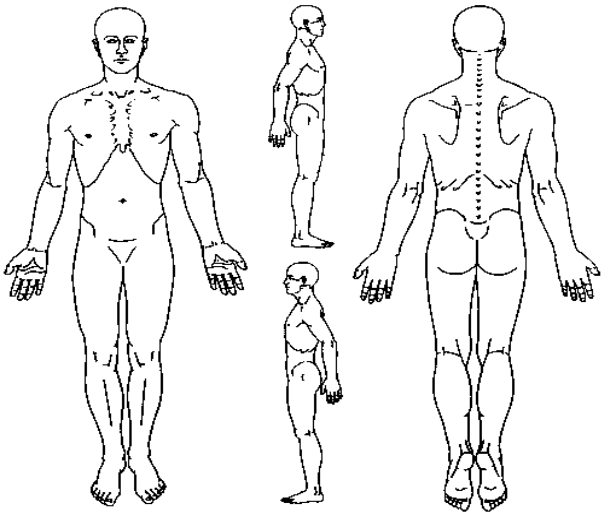
_____

_____

List the maximum amount of time you can tolerate the following activities before you have to move or stop:

Sitting _____ Walking _____ Standing _____ bending _____ Squatting _____ Looking up/down _____ Reaching _____

PLEASE INDICATE ON THE DRAWING BELOW THE LOCATION OF YOUR SYMPTOMS



When did your present pain or injury begin?_____

Have you ever had anything like this before? Yes / No.

Explain:_____

What increases your pain:_____

What decreases your pain:_____

Rate today's pain on scale of no pain (0) to Worse pain you can imagine (10): _____

In the last week best and worst pain on scale of 0-10: Best ____ Worst _____

Are you currently working? Full time___ Part time___ Unemployed___ Disability___ Retired___ Modified duty___

Out of work Date:_____ Days missed because of injury?_____

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