PLEASE PRINT

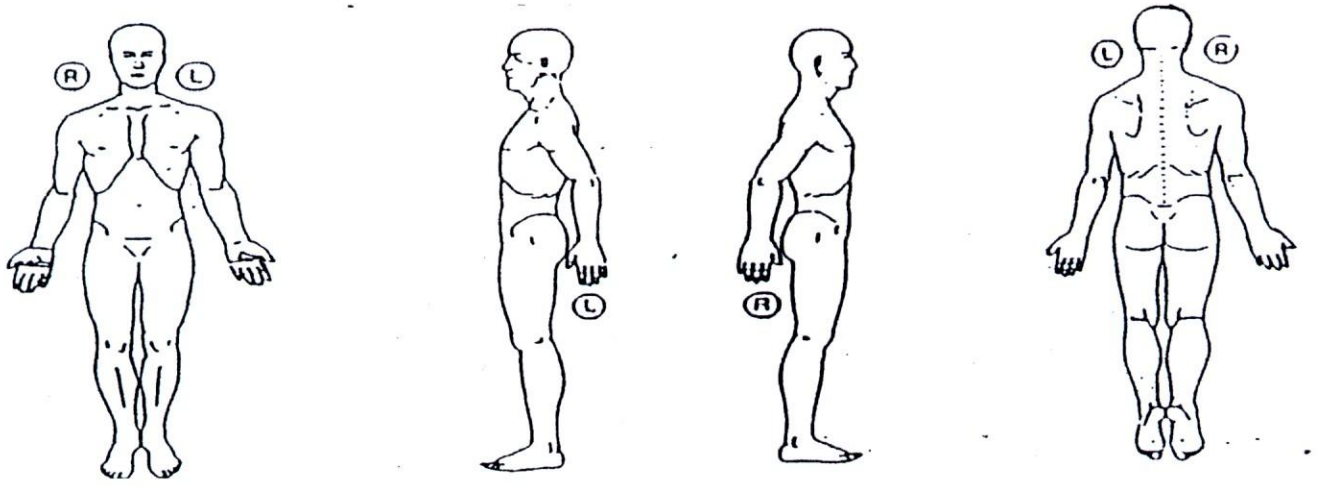
Dr. Bruce C. Diven, PT, DPT
Patient Medical History

PLEASE PRINT

Patient's Name_____ **Date**_____
Your Occupation_____ **Family Physician** _____/**Phone**_____
Orthopedic / Referring Doctor _____**Phone**_____

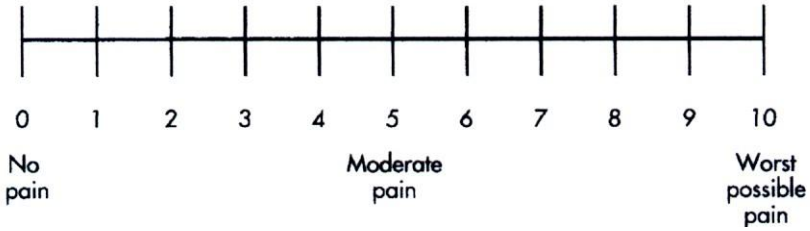
When did your symptoms start? _____(date) **Accident / Injury?** __ _____ (date)
What caused your current problem? _____
Have you had this problem before? ____**No** ____ **Yes – When?** _____
What has changed in the last 90 days that has made you come to therapy? _____
What activities do you have difficulty with because of your current problem? _____**Self Care** /____**Dressing**
____ **Sleeping** / _____**Household Tasks** / _____**Hobbies / Sports : i.e.**_____ / **Driving** _____ **Bending** _____
____ **Lifting or Carrying** / _____ **Work Tasks: i.e.** _____ **OTHER** _____

Are your symptoms getting: _____ **Better** _____ **Worse** _____ **No Change**
What makes your symptoms better? (i.e. specific med, position, etc.)_____
What makes your symptoms worse? _____
Is your pain worse at night? _____**Sleeping position**_____
Describe your PAIN: _____ **Intermittent** _____ **Constant** _____ **Sharp** _____ **Dull** _____**Achy** ____**Shooting**



Draw the areas of pain (//////) ; tingling (XXXX) ; numbness (>>>>>)

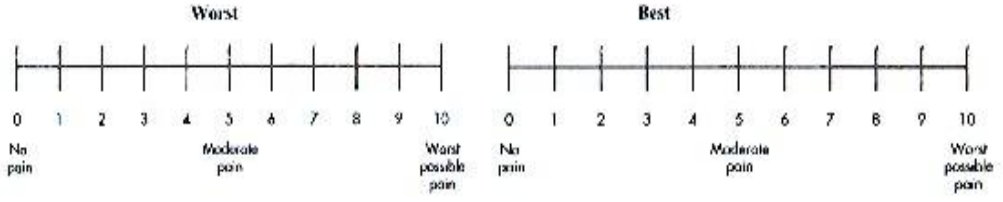
TODAY-PAIN



Circle the number on the graph ABOVE showing your level of pain <u>TODAY</u> (0=NO PAIN / 10=WORST PAIN)

PAST 4 WEEKS

#1 **#2**



Circle the number on the graph showing your HIGHEST (worst) #1 level of pain…What causes this?_____
Circle the number showing the LOWEST (best) #2 level of pain…What position or movement?_____
(0=NO PAIN / 10=WORST)

Tests performed & dates:

X-rays _____ **CT Scan** _____ **MRI** _____ **EMG** _____
Injections / Nerve Blocks _____ **OTHER** _____

Surgery Dates:	**Describe**	**Date**
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Dates of treatment for this problem: Physical Therapy_____ **MD / DO**_____
Chiropractor_____ **OTHER**_____

How are you treating your problem at home? (i.e. heating pad, hot showers, ice) Does it help?
_____

What activities or motions are you UNABLE to do now that you could do before the problem began?
_____

Current Medications:	**Drug Name**	**Condition**
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Do you now or in the past have had problems with:

_____ **Allergies**
_____ **Anemia**
_____ **Anxiety**
_____ **Arthritis / Joint Pain**
_____ **Asthma**
_____ **Balance – Walking or Standing**
_____ **Cancer (**_____**)where?**
_____ **Cardiac Conditions**
_____ **Cardiac Pacemaker**
_____ **Chemical Dependency**
_____ **Circulation / Vascular**
_____ **Currently Pregnant**
_____ **Depression**
_____ **Diabetes / High Blood Sugar**
_____ **Dizzy Spells**
_____ **Emphysema/Bronchitis**
_____ **Fibromyalgia**
_____ **Gallbladder Problems**
_____ **Head Injury**
_____ **Headaches**
_____ **OTHER**_____

_____ **Heart Problems (**_____**) what?**
_____ **Hepatitis**
_____ **High Blood Pressure**
_____ **Heart Attack (**_____**) when?**
_____ **Incontinence**
_____ **Kidney Problems**
_____ **Metal Implants (** _____**)**
_____ **MS/Multiple Sclerosis**
_____ **Osteoporosis**
_____ **Parkinsons**
_____ **Posture – Sit / Stand / Sleep**
_____ **Rheumatoid Arthritis**
_____ **Seizures / Epilepsy**
_____ **Speech Problems**
_____ **Stomach / Intestinal**
_____ **Stroke (**_____**) when?**
_____ **Thyroid (**_____**)**
_____ **Tuberculosis**
_____ **Vision Problems**

_____ **OTHER**_____

What are YOUR goals to achieve in Physical Therapy?

_____ **decrease pain**
_____ **increase strength**
_____ **increase walking distance**
_____ **return to work (**_____**)**
_____ **OTHER**_____

_____ **increase joint motion**
_____ **increase endurance**
_____ **improve ability to do daily activities**
_____ **return to sports activities (**_____**)**
_____ **OTHER**_____

Dr. Bruce C. Diven, PT, DPT
Physical Therapist