Active Balance Physical Therapy, LLC

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PATIENT HISTORY FORM

NAME _____ AGE_____ DATE_____

HEIGHT_____ WEIGHT_____ Dominant side: ☐ R ☐ L ☐ B Injured Side: ☐ R ☐ L ☐ B

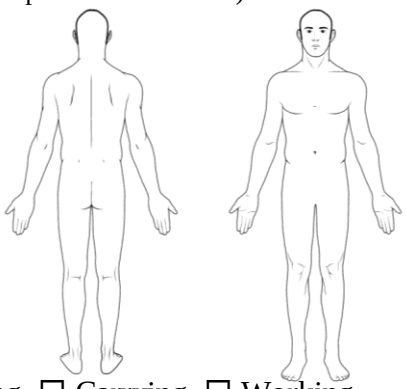
Date symptoms started_____

What are your symptoms? (Check all that apply) ☐ Pain ☐ Numbness ☐ Tingling ☐ Burning ☐ Weakness

Other (please explain) _____

If you were hospitalized for your current symptoms, list dates: _____

(mark problem area below)



Have you had any of the following tests or treatments for your current symptoms? (Check all that apply)

☐ X-ray ☐ MRI ☐ CT Scan ☐ Injections

☐ Physical Therapy ☐ Massage ☐ Chiropractor

Please check any activities that you have difficulty with or are unable to perform due to your symptoms:

☐ Walking ☐ Sitting ☐ Standing ☐ Sleeping ☐ Squatting ☐ Lifting ☐ Carrying ☐ Working

☐ Pushing ☐ Pulling ☐ Driving ☐ Reaching behind back ☐ Reaching overhead ☐ Getting out/into chair

Other (please explain) _____

RATE YOUR PAIN LEVEL NOW: 0 Least 0 1 2 3 4 5 6 7 8 9 10 Greatest

Please list the medications (prescription and over the counter) and dosages that you are currently taking and/or provide the office with a copy of your list of current medications:

_____ _____

_____ _____

Have you been treated for any of the following conditions? (Check all that apply)

☐ Cancer ☐ Diabetes ☐ Cardiac conditions

Do you have a PACEMAKER? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Other Past Medical History _____

Have you fallen in the past 12 months? ☐ Yes ☐ No How many falls? _____

Were you injured in any falls? _____

Are you currently working? ☐ Yes ☐ No Occupation: _____

Employer: _____