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

What activities make the pain worse?

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

What reduces the pain?

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

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

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