EDGE PHYSICAL THERAPY

PATIENT HISTORY

Name: _____ **DOB:** _____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: _____ **Height:** _____ **Weight:** _____

Are you on work restriction from your doctor? YES NO **Are you latex sensitive? YES NO**

Do you smoke? YES NO **Do you have a pacemaker? YES**

FOR WOMEN: Are you currently pregnant or think you mighe be pregnant? YES NO

ALLERGIES: List any medication(s) you are allergic to: _____

How did you hear about us? _____

Have you RECENTLY noted any of the following? (check all that apply)

□ fatigue	□ numbness or tingling	□ constipation
□ fever/chills/sweats	□ muscle weakness	□ diarrhea
□ nausea/vomiting	□ dizziness/lightheadedness	□ shortness of breath
□ weight loss/gain	□ heartburn/indestigation	□ fainting
□ difficulty maintaining balance while walking	□ difficulty swallowing	□ cough
□ falls	□ changes in bowel or bladder function	□ headaches

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

□ cancer	□ depression	□ thyroid problems
□ heart problems	□ lung problems	□ diabetes
□ chest pain/angina	□ tuberculosis	□ osteoporosis
□ high blood pressure	□ asthma	□ multiple sclerosis
□ circulation problems	□ rheumatoid arthritis	□ epilepsy
□ blood clots	□ other arthritic condition	□ eye problem/infectio
□ stroke	□ bladder/urinary tract infection	□ ulcers
□ anemia	□ kidney problem/infection	□ liver problems
□ bone or joint infection	□ sexually transmitted disease/HIV	□ hepatitis
□ chemical dependecy (i.e., alcoholism)	□ pelvic inflammatory disease	□ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions? (check all that apply)

□ cancer	□ diabetes	□ tuberculosis
□ heart problems	□ stroke	□ thyroid problems
□ high blood pressure	□ depression	□ blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? YES NO

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

Have you had physical therapy anywhere else this year? YES NO

If so, when and for how long? _____

What date (roughly) did your present symptoms start? _____

What do you think caused your symptoms? _____

My symptoms are currently: □ Getting Better □ Getting Worse □ Staying about the same

I should not do physical activities that might make my pain worse: □ Disagree □ Unsure □ Agree

Treatment received so far for this problem (chiropractic, injectiions, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: YES NO When: _____ Treatment Rec'd _____

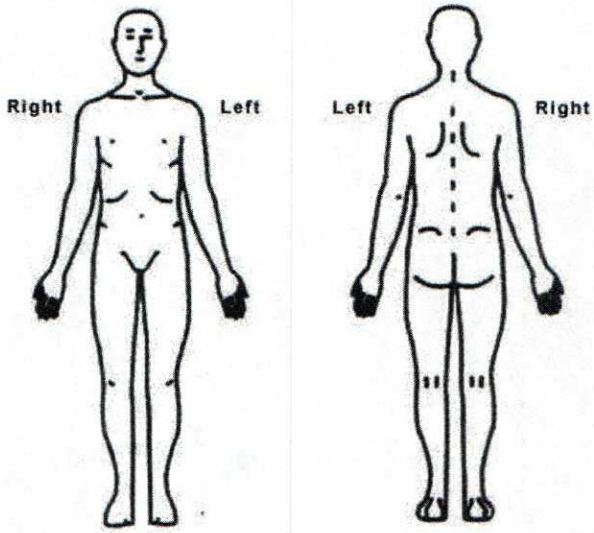
How long did it take for you to feel better?_____

Body Chart:

Please use the symbols to mark the areas where you feel/describe your symptoms using the chart below.

↓ Shooting/sharp pain O Dull/aching pain III

Numbness = Tingling



My symptoms currently: □ Come and go □ Are Constant □ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important postions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make symptoms better:

1. _____
2. _____
3. _____

How are currently able to sleep at night due to your symptoms?

□ No problem sleeping □ Difficulty falling asleep □ Awakened by pain □ Sleep only with medication

When are your symptoms the worst? □ Morning □ Afternoon □ Evening □ Night □ After exercise

When are your symptoms the least? □ Morning □ Afternoon □ Evening □ Night □ After exercise

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Using the 0 to 10 scale, with 0 being "no pain" and 10 being the "worst pain imaginable, please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____