LEVERAGE PHYSICAL THERAPY

PATIENT HISTORY FORM

Name: _____ Today's Date: _____

Date of Birth: _____ Sex: _____ Height: _____ Weight: _____

Occupation: _____

Do you have pacemaker? ☐Yes ☐No Internal Stimulator? ☐Yes ☐No Are you Pregnant? ☐Yes ☐No

Chief Compliant: _____ When did the symptoms start? _____

How did your problem start? _____

Diagnosis: _____ Referral Source: _____

Rate Your Pain: **No Pain 0 1 2 3 4 5 6 7 8 9 10 Worse Pain**

Medical history related to current problem: _____

Surgical history related to current problem: _____

Describe Your Pain:

☐ Dull ☐ Ache ☐ Sharp ☐ Stabbing

☐ Pins & Needles ☐ Shooting ☐ Burning ☐ Throbbing

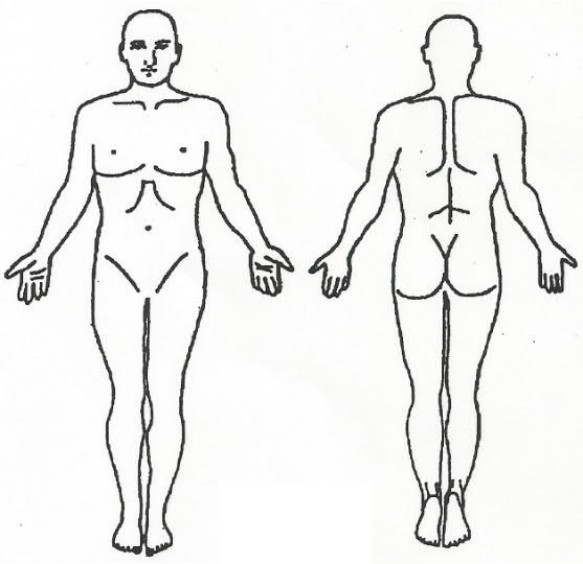
☐ Twinge ☐ Numbness/Tinging ☐ Other _____

Is your pain constant? ☐ Yes ☐ No Intermittent ☐ Yes ☐ No

Fluctuates with activity? ☐ Yes ☐ No

Wakes you up at night? ☐ Yes ☐ No

Draw Your Pain:



What makes your symptoms worse?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting

☐ Bending ☐ Lifting ☐ Bending ☐ Lying down

☐ Squatting ☐ Stress ☐ Other_____

What makes your symptoms better?

☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Lifting ☐ Bending

☐ Lying down ☐ Squatting ☐ Stress ☐ Other_____

What time of day are your symptoms worse? _____ Best? _____

Do you feel you are: ☐ Getting better ☐ Getting worse ☐ Staying about the same

Have you had this problem before? ☐ Yes ☐ No If yes, when, and how did it get better? _____

_____