

# PATIENT HEALTH SUMMARY

Name: \_\_\_\_\_ Age: \_\_\_\_\_ M F DOB: \_\_\_\_\_

Occupation/Student (grade): \_\_\_\_\_ Hand Dominance: R / L (circle one)

Reason you are being seen today: \_\_\_\_\_

Have you had any diagnostic testing for your current condition? If so, what tests: \_\_\_\_\_

Date of injury or when your symptoms began: \_\_\_\_\_

How were you injured? \_\_\_\_\_

Describe your current symptoms: \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

What makes you feel better? \_\_\_\_\_

How long can you stand? \_\_\_\_\_ sit? \_\_\_\_\_ walk? \_\_\_\_\_

Have you experienced a fall within the past 12 months? [ ] Yes [ ] No If so, were you injured? [ ] Yes [ ] No

Do you have a previous history of the condition for which you are being seen today? Yes \_\_\_\_\_ No \_\_\_\_\_

What leisure/physical activities do you enjoy? \_\_\_\_\_

What activities/movements can you no longer do due to your injury? \_\_\_\_\_

What are your goals for therapy? \_\_\_\_\_

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes \_\_\_\_\_ No \_\_\_\_\_

Medication/Injection and condition taken/given for: \_\_\_\_\_

**Please check all that apply to you:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Infectious Disease    | <input type="checkbox"/> Prostate Condition  |
| <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Hepatitis/kidney problems      | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Bowel/bladder       |
| <input type="checkbox"/> High BP/hypertension | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Emotional Problems  |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Phlebitis/Circulatory Problems | <input type="checkbox"/> Thyroid Problems      | <input type="checkbox"/> Migraines/headaches |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Stroke                         | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Dizzy Spells        |
| <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Seizure             |
|   |   | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Tobacco use         |

**Are you currently pregnant?** Yes \_\_\_\_\_ No \_\_\_\_\_

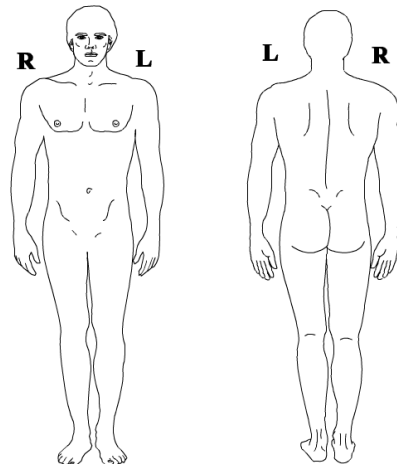
Is there anything else you feel we should be aware of? (fractures, other medical conditions)

List surgeries you've had: \_\_\_\_\_

Circle the number that best describes your status:

Please shade in the areas where you are experiencing pain:

**PAIN**            0   1   2   3   4   5   6   7   8   9   10  
Best \_\_\_\_\_ Worst



Please notify your therapist if there are any changes in your condition.  
Thank you for coming to our clinic for your therapy needs.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_