Bertrand Chaffee Hospital Physical Therapy – Patient History

Please answer the questions below to the best of your ability:

Name: _____ Nickname/Preferred Name: _____

Primary Physician: _____ Referring Physician: _____

Height: _____ Weight: _____ Occupation: _____

Medications: _____

Are you currently taking an anticoagulant (blood thinner)? If yes, please list name: _____

Allergies: _____

Any Metal Implants (ex. joint replacement)? If yes, where?: _____

Do you have a pacemaker (Circle One)? Yes or No Are you receiving any home care services (Circle One)? Yes or No

Have you had any hospitalizations within the last year? _____

Any recent or related surgeries? If yes, please list: _____

Describe the condition for which you're seeking physical therapy services (in your own words):

_____

Please check the following that apply to you:

_____ Heart disease	_____ Epilepsy/Seizures (circle)	_____ Fainting
_____ Fracture	_____ Neurological Problems	_____ Blood Clots
_____ High Blood Pressure	_____ Numbness	_____ Nausea/Vomiting
_____ Migraines/Headaches	_____ Diabetes	_____ Fibromyalgia
_____ Asthma/Breathing Disorder	_____ Weakness	_____ Skin Irritation/Infection
_____ Shortness of Breath	_____ Tremor	_____ Unexplained Weight Loss
_____ Varicose Veins	_____ Cancer/Tumor	_____ Stroke
_____ Neck pain/surgery (circle)	_____ Osteoporosis/Osteopenia (circle)	_____ Arthritis
_____ Back pain/Surgery (circle)	_____ Circulation Problems	_____ Current/Possible Pregnancy

Explanation of Above/Condition Not Listed: _____

_____

When did your current condition begin/surgery occur?: _____

Does the condition for which you are seeking treatment limit your work/leisure/daily activities? If yes, please list: _____

_____

Have you had any testing (X-ray, MRI, CT scan, etc.) for this condition? If yes, please list: _____

_____

Have you received any treatment (physical therapy, chiropractic, injections, etc.) for this condition? If yes, please list: _____

_____

Upon completion of my physical therapy assessment, I understand the findings and proposed treatment regime, as explained by and discussed with the physical therapist. I understand the benefits of the proposed treatment or lack of treatment, the prognosis of meeting the goals of treatment, and the alternatives associated with my care. Based upon this information, I give my informed consent for treatment as proposed.

_____ _____

Date Patient Signature