P.T Services Rehabilitation, Inc. PATIENT HISTORY

Patient to complete the following questions:

1. When did this problem begin? _____ Was it caused by a specific incident? ☐ Yes ☐ N o
   If yes, please explain_____
   _____
   If No, what do you think may be causing this problem? _____
   _____
2. What types of activities or postures aggravate your symptoms? _____
   _____
3. What type of activities or postures relieve your symptoms? _____
   _____
4. When did you last see your doctor? _____ When is your next appointment? _____
5. Have you had any special test to determine the cause of your problem (X-Rays, blood work, MRI, etc.)

   ☐ Yes- please specify_____ ☐ No

6. Are more tests being planned? ☐ Yes ☐ No Explain_____

7. Have you undergone surgery for this problem? ☐ Yes ☐ No If yes, when? _____

8. What medications are you currently taking? _____
9. Do you have any medication or skin allergies? _____

10. Have you had this problem or similar pain before? ☐ Yes ☐ No if yes, when? _____
    What treatment did you receive?_____
    Results: _____

11. Have you received Physical, Occupational or Speech therapy in the past twelve months for this condition?

    ☐ Yes ☐ No Explain_____
    Results_____

12. Please check if you have had or currently have, any of the following medical conditions:

____ Broken Bones	____ Diabetes	____Cancer	____Neurological Problems
____ Trauma	____ Heart Disease	____ Unexplained Weight loss	____ Stroke
____ Metal Implants	____ Pacemaker Implant	____ Kidney Disease	____ Migraine Headaches
____ Arthritis	____ Circulatory Problems	____ Liver Disease	____ Bowel/Bladder Control
	____ High Blood Pressure	____ Infectious Disease	____ Psychological
		____ Lung Disease	____ Seizures

Prior surgeries:_____

13. Please list any recent hospitalizations/reasons/dates: _____

14. Females: Is there a chance you may be pregnant at this time? ☐ Yes ☐ No

15. Are you currently working? ☐ Yes ☐ No If yes, are you under restrictions? ☐ Yes ☐ No
    If yes, Please explain: _____
    _____

If you are not working, is it because of this problem? ☐ Yes ☐ No

How long have you been off work or on restrictions? _____

Do you have a target date set for return to work or getting off the restrictions? ☐ Yes ☐ No Date: _____

16. What is your occupation? _____ What are your job duties? _____
    _____
17. What are your goals for therapy? _____

Patient Signature:	Date:
PT/OT Signature:	Date: