

Paspa Physical Therapy

New Patient History Form

Patient Name: _____ Date: ___/___/___ Diagnosis: _____

Referring MD: _____ Date of first MD visit for this injury: ___/___/___ Next MD appointment? ___/___/___

Gender: M F Birth Date: ___/___/___ Hand dominance: R L Occupation: _____

Have you had any diagnostic tests performed? YES NO If so, indicate which tests & approximate dates:

X-ray: _____ MRI: _____ CT scan: _____ Bone Density: _____ Myelogram: _____

EMG: _____ NCV: _____ Other: _____

Have you missed any work due to this injury? YES NO

If so, last date worked was? _____ Date returned to work? _____ Worked part-time for a period of: _____

Have you had surgery for this injury? YES NO If so, how many surgeries? 1 2 3 4

Procedure(s) performed: _____

Most recent procedure: _____ Surgeon: _____ Date of last surgery: _____

Are you currently taking any prescription or non-prescription medications (for this condition or anything else)? YES NO

Please list in the appropriate categories:

Anti-inflammatory: _____ High Blood Pressure Meds: _____

Muscle Relaxers: _____ Bone Density Drugs: _____

Pain Medication: _____ Beta Blockers: _____

Antibiotics: _____ Other: _____

Have you sought care from any of the following medical providers for this injury/episode?

	YES	NO		YES	NO		YES	NO
Emergency Room Care	___	___	General Practitioner	___	___	Acupuncturist	___	___
Orthopedist	___	___	Physical Therapist	___	___	Massage Therapist	___	___
Neurologist	___	___	Chiropractor	___	___	Other _____	___	___
Podiatrist	___	___	Occupational Therapist	___	___			

When did you first notice symptoms of your problem? _____

Did your symptoms arise gradually? YES NO or Was there sudden onset? YES NO

Was there any trauma/accident that may have caused your complaints/problem? YES NO

Please elaborate: _____

What are your present symptoms? _____

How do your present symptoms compare to your original complaints? _____

Rate your pain on a scale from **0** (no pain) to **10** (excruciating pain that is disabling and requires emergency care)

At the best moment in the last 48 hrs: _____ During the night: _____ At the worst moment in the last 48 hrs: _____

Is your pain **constant** or **intermittent** (circle one)? Does your pain wake you up at night? YES NO

Does your pain fluctuate based on your positions or activities? YES NO

Does your pain follow a pattern whereby it is worse in the **AM** or **PM** (circle one if yes)? YES NO

Does your pain radiate from one area to other areas? YES NO (explain below)

What activities of daily living are painful or difficult for you because of your problem? _____

What can you do to alleviate pain? _____

Do you normally participate in any fitness activities or recreational sports? YES NO

List: _____

How have you modified your activities? _____

Did your referring MD give you any instructions (i.e.: for exercise, weight-bearing, weaning from crutches, use of a brace)?

YES NO Please elaborate: _____

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Orthopedic History:

Please indicate **any musculoskeletal or neurological problems/injuries/surgeries you have experienced in the past**. Include even those that occurred long ago or seem completely unrelated.

CONDITION or INJURY / SURGERY	APPROX. DATES	DO YOU EXPERIENCE RESIDUAL SYMPTOMS?	
		YES	NO
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

General Medical History:

Do you now have or have you ever had ANY of the following:
 YES NO Use this space to explain

Allergies	_____	_____	_____
Anemia	_____	_____	_____
Arthritis: Osteoarthritis	_____	_____	_____
Rheumatoid arthritis	_____	_____	_____
Asthma	_____	_____	_____
Blood Clot/Embolus	_____	_____	_____
Blood Clotting Difficulty	_____	_____	_____
Bowel or Bladder problems	_____	_____	_____
Cancer	_____	_____	_____
Chemotherapy or Radiation	_____	_____	_____
Chest Pain	_____	_____	_____
Chronic Fatigue Syndrome	_____	_____	_____
Coronary Heart Disease or Angina	_____	_____	_____
Coronary Bypass Sx/Angioplasty	_____	_____	_____
Diabetes	_____	_____	_____
Dizziness or Fainting	_____	_____	_____
Emphysema/Pulmonary Problems	_____	_____	_____
Emotional/psychological problems	_____	_____	_____
Epilepsy/seizures	_____	_____	_____
Fibromyalgia	_____	_____	_____
Gout	_____	_____	_____
Headaches (severe or frequent)	_____	_____	_____
Hearing Difficulties	_____	_____	_____
Heart Attack	_____	_____	_____
Hernia	_____	_____	_____
High Blood Pressure	_____	_____	_____
HIV/AIDS	_____	_____	_____
Infectious Diseases	_____	_____	_____
Joint Replacement: (circle)	Hip	Knee	Shoulder Other _____
Lupus	_____	_____	_____
Lyme Disease	_____	_____	_____
Metal Implants or Pins	_____	_____	_____
Muscle Weakness	_____	_____	_____
Neurological Problems	_____	_____	_____
Numbness or Tingling	_____	_____	_____
Osteoporosis	_____	_____	_____
A Pacemaker	_____	_____	_____
RSD	_____	_____	_____
Sarcoidosis	_____	_____	_____
Shingles	_____	_____	_____
Shortness of Breath	_____	_____	_____
Sleeping Problems	_____	_____	_____
Stroke or TIA	_____	_____	_____
Thyroid trouble or goiter	_____	_____	_____
Vascular Problems	_____	_____	_____
Vision Difficulties	_____	_____	_____
Weight/energy loss	_____	_____	_____

Other: _____

Are you pregnant? YES NO **Do you smoke?** YES NO

What are your goals while in this program? _____

Patient/Guardian Signature: _____ Print Name: _____ Date: ___/___/___