ATHLETIC ORTHOPEDICS & KNEE CENTER

FOOT • ANKLE • HAND • PAIN • SHOULDER • SPINE

PHYSICAL THERAPY - PATIENT HISTORY

Name: _____ Date: _____

What body part is injured: _____ RIGHT / LEFT?

Have you had Physical Therapy in this injury before? YES / NO

If yes, with whom and for how long? _____

How did this injury occur? _____

When did this injury occur? _____

On a scale of 0 - 10, with 0 = no pain and 10 = hospitalization, please circle the number that describes your pain level:

○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

None ----------Hospital

Describe your pain (check all that apply)

- Aching ☐
- Throbbing ☐
- Burning ☐
- Stabbing ☐
- Radiating ☐
- Localized ☐
- Constant ☐
- Sharp ☐
- Intermittent ☐
- Dull ☐
- Only when sitting ☐
- Standing ☐

What makes your symptoms worse? _____

What makes your symptoms better? _____

Please list any medications you are currently taking: _____

_____

Please list any other surgeries or hospitalizations you have had in the past: _____

_____

Do you have history of any of the following: (Check all that apply)

- Heart Disease ☐
- Diabetes ☐
- Liver Disease ☐
- Lung Disease ☐
- Anemia ☐
- Stroke ☐
- High Blood Pressure ☐
- Cancer ☐

Do you have a pacemaker? YES / NO

Are you or could you be pregnant: YES NO N/A

Do you have decreased sensation on or around any of the areas being treated? YES / NO

Do you have any metal screws /metal parts on or around the areas being treated? YES / NO

Do you have any unhealed fractures on or around the areas being treated? YES / NO

Do you have any latex allergies on or around the areas being treated? YES / NO