A O K 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 ___	Stabbing ___	Constant ___	Dull ___
Throbbing___	Radiating ___	Sharp ___	Only when sitting ___
Burning ___	Localized ___	Intermittent ___	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