

KETTERING SPORTS MEDICINE CENTER – PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: _____ Age: _____ Hand Dominance: _____
Occupation: _____ Sports: _____
Currently Working? Yes/No _____ hours/week School: _____

What brings you to physical therapy? _____

What do you hope to achieve by coming to physical therapy? _____

Date of onset/injury: _____ Date of surgery: _____

Have you had treatment from a medical practitioner? _____ Describe: _____

Did that treatment help? _____ Explain: _____

Next appointment with practitioner who referred you to physical therapy? _____

Have you had any similar symptoms in the past? _____ If so, explain: _____

Have you been treated for this in the past? _____ If so, explain: _____

What tests have you had for this problem? X-ray bone scan MRI EMG CT Scan _____

Where were tests done? _____

What were the results? _____

Are you currently receiving any other medical/health services? _____

Have you been given exercises or other instructions? _____

Please shade in your area of pain. _____

Where did your pain start: _____

Where did it spread to: _____

Since it started, pain is: getting worse improving the same

Describe pain: sharp dull aching burning throbbing

shooting cramping stabbing sore squeezing

other _____

What makes it worse: _____

What makes it better: _____

Does time of day affect pain? _____

Do wake from sleep due to pain? _____

Rate pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine)

pain at least: 0 1 2 3 4 5 6 7 8 9 10

pain at worst: 0 1 2 3 4 5 6 7 8 9 10

pain now: 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling, numbness or loss of skin sensation: _____ If so, where? _____

What increases this? _____

What decreases this? _____

Do you have any weakness? _____ If so, where? _____

Do you have any swelling? _____ If so, where? _____

Check any activities you have difficulty with due to the problem for which you are seeking treatment:

sleeping rising from a chair bathing job functions: _____

getting in/out of bed prolonged sitting (45 min +) dressing _____

driving prolonged standing self care leisure activities/sports: _____

getting in/out of vehicle walking eating _____

meal preparation using stairs reaching to shelves other: _____

Have you been discharged from a hospital or skilled nursing facility in the last 30 days? _____

If yes, explain: _____

How many times have you fallen in the past year? _____ How many times in the past 2 years? _____

If so, what happened? _____

