PLATINUM CARE PHYSICAL THERAPY

An accurate health history is important to ensure that it is safe for you to receive physical therapy services. All information gathered is confidential as required by law.

PATIENT INFORMATION			
First name:	Last name:	MI:	Date: / /
Address:		City:	
State:	Zip:	Email:	
Phone:	Birth Date: / /	Age:	
Marital Status: M S W D	☐ Male ☐ Female	Number of children:	

How did you hear about us? ☐ Former Patient ☐ Website ☐ Dr. ______________________________
☐ Family/ Friend______________________________________

WORK INFORMATION	
Employer:	
Occupation:	Employment status: ☐ Full time ☐ Part time ☐ Retired ☐ Not Employed

CARE PROVIDER INFORMATION	
Primary Care Physician:	Phone number:

IN CASE OF EMERGENCY		
Name:	Relationship to Patient:	Phone:

PAST MEDICAL HISTORY

CARDIAC

☐ Heart attack
☐ Heart disease
☐ Heart failure
☐ Heart murmur
☐ Heart murmur
☐ High blood pressure
☐ Low blood pressure
☐ Stroke/ CVA
☐ Pacemaker
☐ Angina

RESPIRATORY

☐ Asthma
☐ COPD
☐ Emphysema
☐ Shortness of breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Pneumonia
☐ Sinus problems

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MUSCULOSKELETAL

- ☐ Osteoporosis
- ☐ Osteoarthritis
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Herniated disks
- ☐ Fracture: ___________________________________
- ☐ Joint replacement: ___________________________
- ☐ Sprains: ____________________________________
- ☐ Strains: ____________________________________

OTHER CONDITIONS

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV/ AIDS
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Insomnia / poor sleep
- ☐ Kidney / bladder problems
- ☐ Headaches
- ☐ Allergies: ____
- ☐ Other: ____

Previous surgeries (please include type and date):

List of current medications:

CASE HISTORY

Date of Injury/Onset: / /	Date of Surgery: / /

How did you injure yourself?

Describe your symptoms:

What makes your condition/pain worse?

What makes your condition/pain better?

Please check the most appropriate description of you discomfort:

☐ Achy ☐ Tingling ☐ Cramping ☐ Sharp ☐ Decreased sensation

☐ Dull ☐ Throbbing ☐ Burning ☐ Pins/Needles ☐ Other ___________

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Please check any other symptoms you might have:

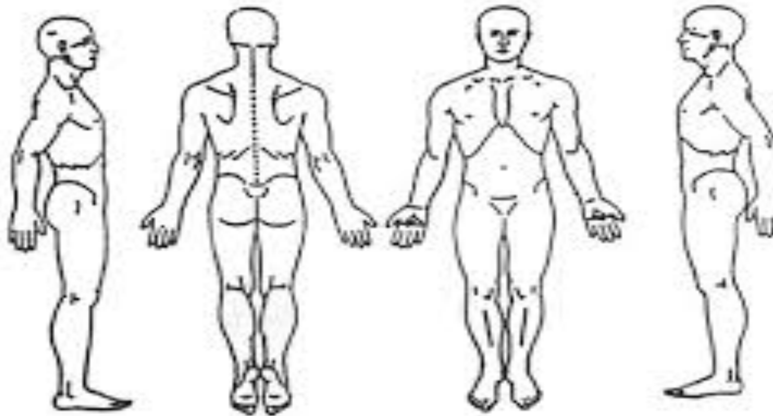
- ☐ Giving way
- ☐ Stiffness
- ☐ Locking
- ☐ Pressure
- ☐ Popping
- ☐ Fainting
- ☐ Dizziness
- ☐ Loss of motion
- ☐ Spasms
- ☐ Swelling
- ☐ Clicking
- ☐ Nausea

Please check activities that are restricted in ability to perform in an efficient, typical, competent, and expected manner:

- ☐ Standing
- ☐ Sitting
- ☐ Driving
- ☐ Walking
- ☐ Stooping
- ☐ Bending
- ☐ Reaching
- ☐ Lunging
- ☐ Shopping
- ☐ Squatting
- ☐ Stairs
- ☐ Kneeling
- ☐ Pulling
- ☐ Pushing
- ☐ Cleaning home
- ☐ Twisting
- ☐ Making beds
- ☐ Taking out trash
- ☐ Showering
- ☐ Sexual Activities
- ☐ Toilet
- ☐ Shaving
- ☐ Washing/Drying Hair
- ☐ Lifting objects from the floor
- ☐ Carrying large objects
- ☐ Putting on/off shirt/jacket
- ☐ Putting on/off socks or shoes
- ☐ Putting on/off pants

Is your condition: ☐ Improving ☐ Worsening ☐ Staying the same

Please mark where you experience symptoms on the diagram:



Please circle on the scale below to indicate your **CURRENT** level of pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle on the scale below to indicate your **WORST** level of pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Please circle on the scale below to indicate your **BEST** level of pain

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable