Progressive Physical Therapy

Medical History

Type of injury: ______________________________ Date of onset: ____________________

Attorney Involved: YES or NO Currently Working: YES or NO

Please describe how injury occurred: ____

List any medications you are presently taking (if any): ____________________________________

Have you had x-rays taken for this injury? yes no

What best describes your pain: sharp dull aching shooting

What best describes your symptoms: constant intermittent (on-and-off during the day) occasional (not every day)

On a scale from 0-10, 0 being no pain, 5 being moderate pain, and 10 being the worst pain imaginable (example, needing an ambulance), please rate your pain based on the last 30 days: _____ Now _____Best _____ Worst

What makes your pain feel worse? (circle all that apply)

Sitting	Laying down	Reaching
Standing	Walking	Bending
Leaning	Stooping	Lifting
Climbing	Driving	Dressing

What makes your pain feel better?

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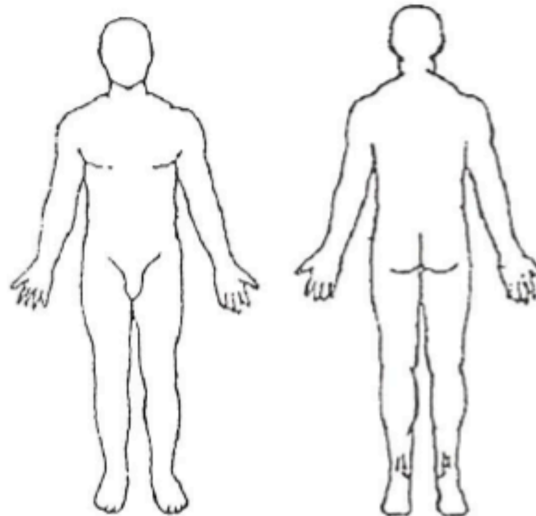
Please mark on the diagram the location of symptoms you are currently feeling:

X Pain

.... Numbness

------ Tingling



Circle YES or NO

History of Allergies? YES NO

Do you have a history of Cancer? YES NO

Do you have a pacemaker? YES NO

Do you have Hypertension? YES NO

Do you have BowellBladder problems? YES NO

Are you Diabetic? YES NO

Are you pregnant? YES NO

Are you happy with your weight? YES NO

Please list any comments or concerns:

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Please list any other relevant past medical or orthopedic history: ______________________________

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