SUMMIT PHYSICAL THERAPY

PATIENT INFORMATION

Name _____ Age _____

What problem(s) are you being treated for today? (Please describe type and location of symptoms):

_____

_____

What date did your symptoms begin? _____

What caused your symptoms to begin? _____

Are your symptoms currently: GETTING BETTER GETTING WORSE NO CHANGE

What makes your symptoms BETTER? _____

What makes your symptoms WORSE? _____

What time of the day are your symptoms worse: MORNING AFTERNOON EVENING SLEEPING

Have you received any treatment for this problem? (chiropractic, acupuncture, injections, therapy, etc.?)
_____

Have you received physical therapy for this condition in the last year? NO YES (#of treatments) _____

Have you had any imaging done for this problem?

X-RAY MRI CT SCAN BONE SCAN OTHER _____

Please indicate any known results of these tests: _____

MEDICAL HISTORY

Have you recently noted any of the following (please check all that apply):

◻ Changes in bowel or bladder	◻ Headaches	◻ Weight loss/gain
◻ Dizziness/lightheadedness	◻ Pain at night	◻ Shortness of breath
◻ Difficulty maintaining balance	◻ Nausea/vomiting	◻ Changes in appetite
◻ Numbness/tingling	◻ Weakness/fatigue	◻ Difficulty swallowing
◻ Fever/chills/sweats		

Past medical history (please check all that apply):

◻ Falls	◻ Pacemaker	◻ Multiple Sclerosis
◻ Hypertension	◻ High Cholesterol	◻ Rheumatoid Arthritis
◻ Osteopenia	◻ Osteoarthritis	◻ Osteoporosis
◻ Neuropathy	◻ Diabetes	◻ Gastro/Intestinal

◻ Auto Immune (is yes, type): _____
◻ Cancer (is yes, type): _____
◻ Heart History (if yes, please explain): _____
◻ Surgeries (if yes, please list): _____

(cont. on next page)

Known allergies (please check all that apply):

- ◻ Seasonal ◻ Adhesive ◻ Latex
- ◻ Medications (if yes, please list): _____
- ◻ Other: _____

Are you pregnant? NO YES (#of weeks): _____

During the past month, have you been feeling down, depressed, or hopeless? NO YES

During the past month, have you been having little or no interest in doing activities? NO YES

Is this something you would like help with? NO YES YES, but not today

MEDICATIONS

Please list all medications, vitamins, supplements, and over-the-counter drugs you are currently taking. If you have a list, please provide it and we can make a copy.

Name	Dose (how much)	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Residence: House Condo/apartment Group residence Nursing Home

Number of stairs in your home: _____ Do you live alone? YES NO

Occupation: _____

Are you currently: FULL DUTY LIGHT DUTY NOT WORKING (last day worked): _____

Leisure activities/hobbies/exercise routine: _____

Do you use tobacco? YES NO Alcohol intake and frequency: _____

Is there anything else pertinent to your treatment? _____

What are your goals for therapy? _____

The above information is true, complete, and accurate to the best of my knowledge.

_____

Print patient name

_____

Patient signature (Parent/Guardian if patient under 18) Date