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 PHYSICAL/OCCUPATIONAL THERAPY OTHER_____

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

Have you had a special tests for this problem (circle all that apply)?

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

Please list any past medical history (falls, pacemaker, surgeries) and dates in which they occurred: _____

_____

Please list any known allergies (latex, adhesives)_____

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 and we can make a copy

Name	Dose (how much)	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you allergic to any medication? Please indicate_____

SOCIAL HISTORY

Home: 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.

Patient/Guardian Signature_____ Date _____