NORTH COAST
PHYSICAL THERAPY

PATIENT HISTORY

Name_____ Date:_____

HAVE YOU SEEN A PHYSICIAN AND/OR RECEIVED ANY MEDICAL TREATMENT FOR THIS CONDITION? **If yes please explain**_____

_____

***HAVE YOU HAD ANY HOME HEALTH THIS YEAR? YES / NO (please circle one)**
***IS TODAY'S APPOINTMENT DUE TO AN AUTO ACCIDENT? YES / NO (please circle one)**

Please describe your current symptoms_____

_____

***What was the exact date your symptoms / injury occurred?** _____

How did your symptoms / injury first occur? _____

What is your occupation? _____

What activities / positions relieve your pain? _____

What activities / positions aggravate your pain? _____

Please rate your pain on a scale from 0-10 (0=no pain and 10=worst pain)

Now_____ Best_____ Worst_____ On average_____

How many minutes can you sit_____, drive_____, walk_____, stand_____?

Circle if you have experienced any of these medical problems:

Heart problems	High blood pressure	Anxiety, stress, phobias, panic attacks	Cancer
Diabetes	Low blood pressure	Loss of consciousness or seizures	Arthritis
Anemia	Thyroid problems	Low blood sugar	Asthma
Arthritis	Sinus problems	Glaucoma	Depression
Stroke	Cataracts	Macular Degeneration	Chronic Fatigue

If yes, please explain: _____

_____

Please list any other medical conditions, allergies or past surgeries: _____

_____

Please list any current medications and dosage: _____

_____

_____