A STEP AHEAD PHYSIOTHERAPY
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Patient Health History

Patient Information

Age _____

Date _____

Occupation _____

Name _____

Onset of symptoms _____
(Approximate Date)

Patient History

(Check all that apply)

How did the symptoms start?
☐ Suddenly ☐ Pulling
☐ Gradually ☐ Injured at work
☐ Lifting ☐ Bending
☐ No apparent reason

What makes the symptoms worse?
☐ Exercise (during) ☐ Bending forward
☐ Exercise (after) ☐ Bending backwards
☐ Sitting ☐ Coughing
☐ Walking ☐ Sneezing
☐ Lying down

What reduces the symptoms?
☐ Lying down ☐ Pain pills
☐ Sitting ☐ Injection for pain
☐ Standing ☐ Muscle relaxants
☐ Walking ☐ Nothing
☐ Heat / Cold ☐ Anti-inflammatories
☐ Other

How long have you had symptoms?
_____Years _____ Months _____ Weeks

Have you ever had similar symptoms?
☐ No
☐ Yes, when? _____

Have you had any of these tests?
☐ X-rays Date _____
☐ CT Scan Date _____
☐ MRI Date _____
☐ Ultrasound Date _____

Have you been hospitalized for your problem?
☐ No ☐ Yes, when? _____

Have you had surgery for your problem?
☐ No ☐ Yes, when? _____

Have you had any other surgeries?
☐ No ☐ Yes, what/when? _____

Have you sought previous treatment for this?
☐ No ☐ Massage ☐ Chiropractor
☐ Physio ☐ Psychiatrist ☐ Other

Does this condition prevent you from working?
☐ No ☐ Yes, how long off work_____
☐ Restricted, explain _____
_____

List physical activities you participate in regularly
_____
_____

List all medication/vitamins/supplements you are currently taking:
_____
_____

Is an attorney involved with the case?
☐ No ☐ Yes

Check all that apply to you either past or present

No	Yes		No	Yes	
☐	☐	Arthritis/joint difficulties	☐	☐	Night sleep disturbance
☐	☐	Rheumatoid Arthritis	☐	☐	Do you awaken from pain?
☐	☐	Osteoporosis	☐	☐	Do you have constant pain?
☐	☐	High blood pressure	☐	☐	Change in bowel/bladder habits
☐	☐	Heart disease	☐	☐	Frequent urination
☐	☐	Circulatory disorders	☐	☐	Unusual fatigue/weakness
☐	☐	Lung problems	☐	☐	Nausea or vomiting
☐	☐	Asthma	☐	☐	Fever or chills
☐	☐	Stroke (CVA)	☐	☐	Changes in memory
☐	☐	Dizziness – blackouts	☐	☐	Seizures – nerve disorders
☐	☐	Cancer or tumors	☐	☐	Frequent or easy bruising/bleeding
☐	☐	Gout	☐	☐	Frequent cramping
☐	☐	Diabetes	☐	☐	Hypoglycemia
☐	☐	Visual problems	☐	☐	Hearing problems
☐	☐	Allergies	☐	☐	Allergies to tapes or lotion
☐	☐	Are you pregnant?	☐	☐	Planning on becoming pregnant?
☐	☐	Do you smoke? _____ #/Day	☐	☐	Do you drink? _____ #/Day

Have you recently experienced significant changes in:

No	Yes		No	Yes	
☐	☐	Mood	☐	☐	Interest or pleasure in daily activities
☐	☐	Loss/gain of appetite, weight loss/gain	☐	☐	Energy level
☐	☐	Sleeping habits	☐	☐	Recurrent thoughts of death/harming yourself

Are you aware of your current diagnosis? ☐ No ☐ Yes

Do you have questions regarding your diagnosis or prognosis? ☐ No ☐ Yes

Please indicate where your symptoms are located

Stabbing Pain	//////////
Burning Pain	XXXX
Dull/Aching	00000
Numbness	~~~~~
Pins and Needles	+++++

_____
Pain Level
(0-10)