

## PATIENT HEALTH SUMMARY

**Name:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **M** **F** **DOB:** \_\_\_\_\_

**Occupation/Student (grade):** \_\_\_\_\_ **Hand Dominance:** R / L (*circle one*)

**Reason you are being seen today:** \_\_\_\_\_

**Have you had any diagnostic testing for your current condition? If so, what tests:** \_\_\_\_\_

**Date of injury or when your symptoms began:** \_\_\_\_\_

**How were you injured?** \_\_\_\_\_

**Describe your current symptoms:** \_\_\_\_\_

**What makes your symptoms worse?** \_\_\_\_\_

**What makes you feel better?** \_\_\_\_\_

**How long can you stand? \_\_\_\_\_ sit? \_\_\_\_\_ walk? \_\_\_\_\_**

**Have you experienced a fall within the past 12 months? [ ] Yes [ ] No If so, were you injured? [ ] Yes [ ] No**

**Do you have a previous history of the condition for which you are being seen today? Yes \_\_\_\_\_ No \_\_\_\_\_**

**What leisure/physical activities do you enjoy?** \_\_\_\_\_

**What activities/movements can you no longer do due to your injury?** \_\_\_\_\_

**What are your goals for therapy?** \_\_\_\_\_

**Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes \_\_\_\_\_ No \_\_\_\_\_**

**Medication/Injection and condition taken/given for:** \_\_\_\_\_

**Please check all that apply to you:**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Emphysema                      | <input type="checkbox"/> Infectious Disease    | <input type="checkbox"/> Prostate Condition  |
| <input type="checkbox"/> Heart Condition      | <input type="checkbox"/> Hepatitis/kidney problems      | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Bowel/bladder       |
| <input type="checkbox"/> High BP/hypertension | <input type="checkbox"/> Tuberculosis                   | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Emotional Problems  |
| <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Phlebitis/Circulatory Problems | <input type="checkbox"/> Thyroid Problems      | <input type="checkbox"/> Migraines/headaches |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Stroke                         | <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Dizzy Spells        |
| <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Seizure             |
|   |   | <input type="checkbox"/> Neurological Disorder | <input type="checkbox"/> Tobacco use         |

**Are you currently pregnant?** Yes \_\_\_\_\_ No \_\_\_\_\_

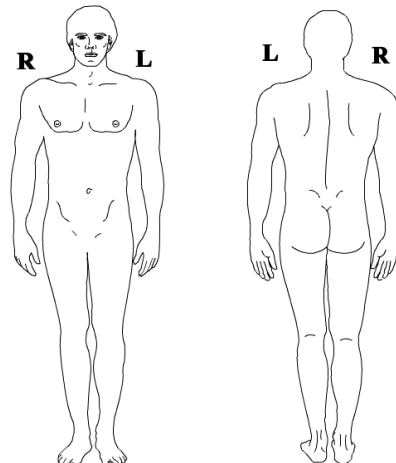
Is there anything else you feel we should be aware of? (fractures, other medical conditions)

List surgeries you've had: \_\_\_\_\_

*Circle the number that best describes your status:*

*Please shade in the areas where you are experiencing pain:*

**PAIN**                    0   1   2   3   4   5   6   7   8   9   10  
Best \_\_\_\_\_ Worst



Please notify your therapist if there are any changes in your condition.  
Thank you for coming to our clinic for your therapy needs.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_