SMITH & PROTHERO PHYSICAL THERAPY
PATIENT HISTORY FORM

Patient Name: ______________________________ Date: ______________

Occupation/Employer: ______________________________ Work Status: ______________

Referring Physician: ______________________ Next Scheduled Appointment: ______________

Primary Care Physician: ______________________

How did you hear about our office? ______________________

Current Injury/Complaint

1. Date of Injury/Start of Complaint: ______________________
2. Briefly describe your symptoms. *(Indicate on the diagram where your symptoms are located.)* ______________________
   ____
3. How did your symptoms start? ______________________
   ____
4. What is the severity of your pain? Min 1 ----- 2------ 3------ 4------ 5------ 6------ 7------ 8------ 9----- 10 Max
5. What is the nature of your pain? (Check all that apply)
   ☐ Occasional ☐ Constant ☐ Sharp ☐ Throbbing
   ☐ Intermittent ☐ Aching ☐ Dull ☐ Other ______________
6. Does pain wake you at night? ☐ Yes ☐ No
7. What is your most comfortable activity/position? ______________________
8. What is your least comfortable activity/position? ______________________
9. Since the onset, how have your symptoms changed? ☐ Better ☐ Worse ☐ No Change
10. As the day progresses, how do your symptoms change? ☐ Increase ☐ Decrease ☐ No Change
11. With regard to this complaint, have you…

	Yes	No
…experienced similar symptoms in the past?	☐	☐
…had previous treatment?	☐	☐
…had surgery?	☐	☐
…received home health care?	☐	☐

    If you answered yes to any of the above, please provide brief explanation (including dates): ______________________
    ____

12. Have you had any diagnostic testing (MRI, x-ray, etc.)? (Please specify.) ______________________
13. Is this complaint/injury related to any of the following?

	Yes	No
Auto Accident	☐	☐
Work Accident	☐	☐
Liability Accident	☐	☐
Other Accident (fall, sports, etc.)	☐	☐

14. What are your goals for treatment? ______________________
    ____

Social/Living History

15. Do you have stairs at home? ☐ Yes ☐ No If yes, how many? ______________
16. How many adults live in your home? ______________ How many children? ______________

Patient Name: ____ Date: ________________

17. Does anyone help you with activities such as shopping, cleaning, cooking, yard work, etc.? ☐ Yes ☐ No

If yes, provide details such as who and with what activities. ____

____

18. Rate your overall ability to perform functional activities:

Very Poor 1 -------------------- 2 ----------------------3----------------------4 -------------------5 *Very Good*

19. Do you use a cane, crutches, wheelchair, or walker? ☐ Yes (indicate) ☐ No

20. Are you currently applying for or receiving disability? ☐ Yes (indicate) ☐ No

Personal Medical History

21. Check all conditions that apply to your personal medical history. If not listed, check other and provide a description.

☐ Current Pregnancy	☐ Circulation Problems	☐ Multiple Sclerosis
☐ Broken Bone/Orthopedic Problems	☐ Lung/Breathing Problems	☐ Parkinson's disease
☐ Arthritis/Rheumatoid Arthritis	☐ Diabetes	☐ Stroke
☐ Osteoporosis	☐ Gastrointestinal Problems	☐ Skin Diseases
☐ Fibromyalgia	☐ Thyroid problems	☐ Infectious Diseases
☐ Heart Conditions	☐ Mental/Behavioral Disorder	☐ Cancer
☐ High Blood Pressure	☐ Depression/Anxiety	☐ Allergies
☐ High Cholesterol	☐ Epilepsy/Seizures	☐ Other ________________

If you checked any of the listed conditions, provide brief explanation: ________________________________

____

22. Do you smoke? ☐ Yes ☐ No If yes, how often? ________________________

23. Do you drink? ☐ Yes ☐ No If yes, how often? ________________________

24. Do you exercise? ☐ Yes ☐ No If yes, how often? ________________________

25. What is your height? ____________________ What is your weight? ____________________________

26. Have you had any physical therapy in the past year? If yes, provide brief explanation (when, why, where, etc.). __________

____

27. List any hospitalizations within the last 2 years:

Date	*Reason for Hospitalization*
____________________	____
____________________	____

28. Aside from this most recent complaint/injury, how would you rate your overall health?

Very Poor 1 -------------------- 2 ----------------------3----------------------4 -------------------5 *Very Good*

Current Medications: *Name/Purpose*	*Dosage*	*Frequency*
______________________________________	______________	______________
______________________________________	______________	______________
______________________________________	______________	______________
______________________________________	______________	______________
______________________________________	______________	______________

Additional Comments: ____

Patient Signature: _________________________ **Therapist Signature:** _________________________