Patient Name _____

DOB _____/_____/_____ Age _____

Height _____ Weight _____

Date _____

EAST SACRAMENTO PHYSICAL THERAPY

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Patient History

1. Describe current problem that brought you here: _____

_____

2. When did your problem begin (approximate date)? _____

Was your first episode related to a specific incident? _____

3. Have you had any surgeries? If so, list type and approximate dates: _____

_____

4. Have you had any hospitalizations related to this problem? If so, list reason and approximate dates: _____

_____

5. Pain: If present, please rate your pain on a scale of 0-10 (0 = none, 5 = moderate, 10 = extreme)

Pain is at best: _____ Pain is at worst _____ Current pain level _____

Describe the nature of your pain. Please check all that apply:

☐ Constant	☐Numbness/ Tingling	☐Worst in the A.M.	☐Getting better
☐ Intermittent	☐Shooting	☐Worst in the P.M.	☐Getting worse
☐Burning	☐Dull/ Achy	☐Worst at night	☐Staying the same
☐Throbbing		☐Other_____	

6. What activities cause or aggravate your symptoms? Check all that apply:

☐ Sitting greater than ___ minutes	☐ Bending	☐ Cough/ sneezing/ laughing
☐ Standing greater than ___ minutes	☐ Voiding	☐ Cold weather
☐Walking greater than ___ minutes	☐ Lying down	☐ With triggers (i.e. key in door)
☐ Stairs: ___ Up ___ Down	☐ Vigorous activity/ exercise	☐ With nervousness/ anxiety
☐ Changing positions (i.e. sit to stand)	☐ Sexual activity	☐ No activity affects the problem

7. What, if anything, relieves your symptoms? _____

8. Do you have a previous history of similar symptoms (approximate dates)? _____

9. Describe any previous treatments/ exercises: _____

Did you have success with previous treatment? ☐Yes ☐No

10. What is your living situation?

□ Assisted Living □ Live with partner □ Live with caregiver □ Live with family
□ Single/ Widowed □ Receiving home health care □ Other_____

11. Occupation: _____ Circle all that applies: Full time/ Part time/ Retired/ Disability/ Leave

12. Amount and type of exercise per week: _____

13. If applicable (Please write number of each)

__ Pregnancies __Vaginal deliveries __ Episiotomies __ C- Sections

Have you experienced a difficult childbirth? (explain) _____

15. Have you ever had any of the following conditions or diagnosis (please circle all that apply)

Smoking/ tobacco use	High blood pressure	Pelvic Congestion	Childhood bladder problems
History of falling	Cancer:_____	PID	Depression/ Anxiety
Physical/sexual abuse	immunosuppression	Pudenda Neuralgia	Chronic fatigue Syndrome
Heart Problems	lupus	Pelvic pain	Joint replacement
Cauda Equina	Obesity	Prostate Disorder	Sports Injuries
Stroke	Arthritis	TMJ/ Neck Pain	Latex Sensitivity
Current Infection	Head Injury	Headaches	Irritable Bowel Syndrome
Diabetes Type I/ II	Dysmenorrhea	Osteoporosis	Sexually transmitted Disease
Fibromyalgia	Endometriosis	Epilepsy/ Seizures	Menopause (when)_____
Fracture:_____	FibroidsMultiple	Sclerosis	Other:_____

16. Have you had any diagnostic testing or imaging related to this problem? (type/ results) _____

_____

17. Since the onset of your symptoms, have you had: (circle any that apply)

□Unexplained weight change	□ Unexplained weakness	□Worst in the A.M.	□Getting better
□ Fever/chills	□ Night pain/ sweats	□Worst in the P.M.	□Getting worse
□Dizziness/ fainting	□ Numbness/ tingling	□Worst at night	□Staying the same
□ Other:_____			

18. Medications/ Supplements/ Herbal (pills, injections, patch, etc. Please include birth control and OTC)

Prescription?	Reason	State Date	Reason
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			

19. What are your goals for treatment? _____