Patient Name _____

DOB _____/_____/_____ Age _____

Height _____ Weight _____

Date _____

East Sacramento Physical Therapy
3400 Elvas Avenue Sacramento CA 95819
Phone 916-457-8802 Fax 916-457-7609

Patient History

1. Describe the current problem that brought you here: _____

_____

2. When did your problem first 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 pain is present, please rate your pain on a scale of 0-10 (0=none, 5=moderate, 10= extreme).

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

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

__ Constant	__Numbness/ Tingling	__Worse in the AM	__Getting better
__ Intermittent	__ Shooting	__Worse in the PM	__ Getting worse
__ Burning	__ Dull/Achy	__Worse at night	__ Staying the same
__ Throbbing		__ Other _____	

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

__ Sitting greater than ___ minutes	__ Bending	__Coughing/sneezing/laughing
__ Standing greater than __ minutes	__Voiding	__Cold weather
__Walking greater than __ minutes	__ Lying down	__ With triggers (ie key in door)
__ Stairs __Up __ Down	__Vigorous activity/exercise	__With nervousness/ anxiety
__Changing positions (ie sit to stand)	__Sexual activity	__No activity affects the problem

   __Other, please list _____

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