Community Rehab Physical Therapy

Patient Medical History

Name:_____ Date:_____

Occupation:_____ Work Status: FT/PT/Out/Light Duty

Past Medical History: (HTN,Cancer,Diabetes,Pacemaker,Surgeries,etc. and date)

_____

_____

Medications:_____

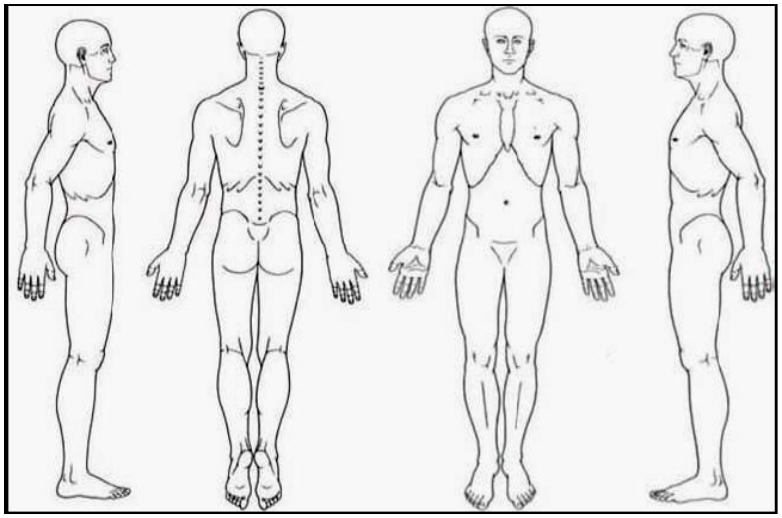
_____

Allergies:_____

Date and Mechanism of Injury:_____

_____

Shade in Areas of pain or dysfunction:



Pain Scale:
0 = nothing
1 = very weak
2 = weak
3 = moderate
4 = somewhat strong
5 = strong
6 = very strong
7 = very, very strong
8 = extremely strong
9 = nearly unbearable
10 = unbearable, ER pain
On your:
Best day:_____
Worst day:_____
Pain now:_____

Prior Treatment or Intervention:_____

_____

Aggravating Factors: (prolonged sitting,walking,reaching,etc.):_____

_____

Relieving Factors: (sitting,bed rest,standing,heat,ice,etc.):_____

_____

List any recent diagnostic tests: (x-rays,MRI,US,Bone Scan,NCV,CT scan):_____

_____