LARCHMONT PHYSICAL THERAPY

PATIENT HISTORY

1 Do you, or have you had, any of the following?

			If yes, please explain.
High blood pressure	NO	YES	
Respiratory disorders / asthma	NO	YES	
Heart disease	NO	YES	
Cardiovascular disease	NO	YES	
Epilepsy / seizures	NO	YES	
Diabetes -- Type 1 or type 2	NO	YES	
Cancer	NO	YES	
Arthritis / osteoarthritis	NO	YES	
Osteoporosis	NO	YES	
Immune deficiency disease	NO	YES	
Depression / Anxiety	NO	YES	
Vision or hearing problems	NO	YES	
Allergies	NO	YES	
Smoke (if yes, for how long?)	NO	YES	
Other	NO	YES	

2 Please list any surgeries you've had or accidents for which you have been hospitalized:

DATE	SURGERY / REASON

3 Do you have any **metal** anywhere in your body (pins, pacemaker, etc)? _____

4 Please list any medications you are currently taking:

_____

_____

_____

CURRENT SYMPTOMS

5 Onset date: _____ **6** Please describe your injury or chief complaint: _____

_____

7 List any recent imaging you've had (CT scan, MRI, X-rays): _____

8 In the past 4 weeks, what's your *average* pain / symptom level: 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

9 How often do you experience your pain / symptom?

- ☐ Constantly (90% or more of the day)
- ☐ Frequently (51-75% of the day)
- ☐ Occaisionally (26-50% of the day)
- ☐ Intermittently (1-25% of the day)

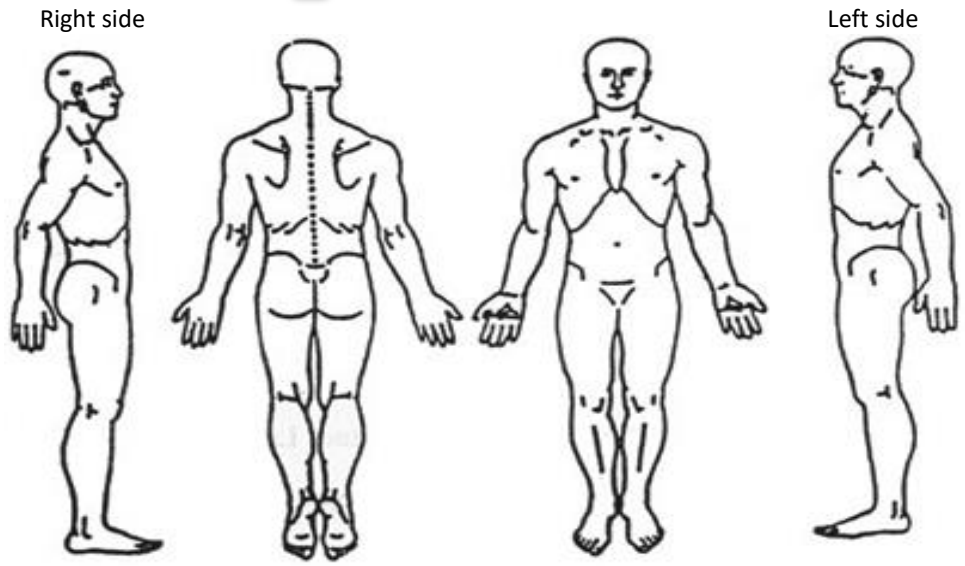
10 How are your symptoms changing?

- ☐ Getting better
- ☐ Getting worse
- ☐ Staying the same

11 Describe the nature of your symptoms:

- ☐ Sharp
- ☐ Throbbing
- ☐ Radiating
- ☐ Tingling
- ☐ Tender
- ☐ Stiffness
- ☐ Numbness
- ☐ Dull ache
- ☐ Burning
- ☐ Shooting
- ☐ Pins and needles
- ☐ Cramping
- ☐ Other: _____

12 Indicate on the image where you are experiencing your pain / symptoms: ⇨



Name: _____ Height: _____ Weight: _____ Date: _____