Manchester Physical Therapy

Effective, professional, individualized treatments to achieve optimal recovery and wellness.

Patient Name: _____ Date: _____

DOB: _____ Age: _____ Smoker? Yes No

MD: _____ Problem/Diagnosis: _____

Weight: _____ Height: _____ Date of injury/onset: _____

Past Medical History: *Check any condition that you have or had:*

❑ Cancer	❑ Parkinson Disease	❑ Kidney problems
❑ High Blood Pressure	❑ Infectious Disease	❑ Multiple Sclerosis
❑ Osteoporosis	❑ Thyroid problems	❑ Broken bones/fractures
❑ Allergies	❑ Skin Disease	❑ Liver Disease
❑ Diabetes	❑ Ulcers/Stomach problems	❑ Head injury
❑ Heart problems	❑ Stroke	❑ Asthma
❑ Arthritis	❑ Depression	❑ Lung problems
❑ Seizures/Epilepsy	❑ Fibromyalgia	❑ Bowel or Bladder Problems

❑ Other: _____

Past Surgical History: _____

Current Medications: _____

Where is your pain (if applicable): _____

Describe current pain/symptoms: _____

What date (approximately) did your present pain start? _____

How? (gradually, suddenly, injury) _____

My symptoms are currently: ❑ getting better ❑ about the same ❑ getting worse

What treatments have you received for this problem so far? _____

Have you had an x-ray, MRI or other tests for this problem? _____

Is your pain affecting your sleep? Yes No

What makes your symptoms better? _____

What makes your symptoms worse?

Pain quality: ❑ dull ❑ sharp ❑ throbbing ❑ burning ❑ ache ❑ other: _____

Pain frequency: ❑ less than daily ❑ daily ❑ increases throughout the day ❑ constant
❑ night pain ❑ other:

Using the scale below, enter the number for your pain at its worst _____ best _____ current _____

No Pain — Worst Pain Imaginable

0 1 2 3 4 5 6 7 8 9 10

What are your personal goals for therapy at this time? _____

Have you had any falls in the past 12 months?

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