OAKBEND PHYSICAL THERAPY

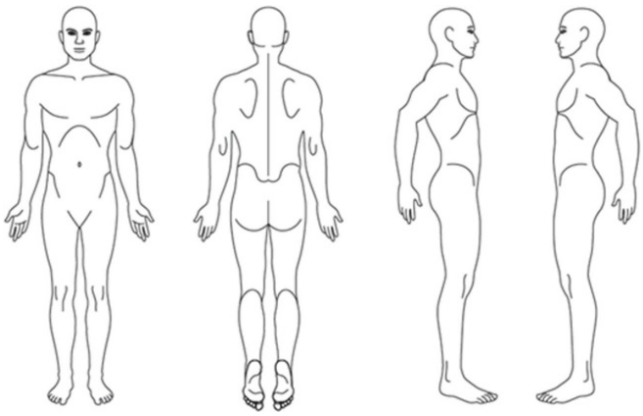
Managed by AFFILIATES in PHYSICAL THERAPY

PATIENT HEALTH INFORMATION

Name _____ Signature _____

Date _____/_____/20_____ Height _____ Weight _____

MARK PAINFUL AREA/S WITH AN X



1. Primary current complaint or problem we are seeing you for today:

_____

2. Date when problem/injury began: _____

3. Briefly describe how injury/problem occurred: _____

_____

4. Did you have a recent X-Ray and/or MRI performed on this body part/area? **Yes / No** Date ____ / ____ /20____

   Requesting physician: _____

5. List activities or positions that make the pain worse in this area: _____

   _____

6. Average pain over the past 24 hours: (none/no pain) **0** **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** (very severe)

7. Pain description (check all that apply): ☐ sharp ☐ dull ☐ achy ☐ tingling ☐ numb ☐ throbbing ☐ shooting ☐ stabbing ☐ burning ☐ radiating

   Other (please describe): _____

8. Have you ever received physical therapy care? **Yes / No** If yes, **When** and **What** problem/body area was treated?

   _____

9. Are you currently receiving any form of home health services? **Yes / No** For What? _____

10. Job title/description: _____ Is your current injury work related? **Yes / No**

CHECK ANY SYMPTOMS/CONDITIONS YOU ARE ***CURRENTLY*** EXPERIENCING:

☐ Neck Pain	☐ Asthma	☐ Joint Swelling	☐ Chest Pains
☐ Neck Stiffness	☐ Allergies	☐ Diabetes	☐ Shortness of Breath
☐ Pain in Hands or Arms	☐ Nervousness	☐ Menstrual Cramps	☐ Dizziness
☐ Irritability	☐ Stomach Upset	☐ Loss of Balance	☐ Pain between Shoulders
☐ Loss of Memory	☐ Constipation	☐ High Blood Pressure	☐ Shoulder Pain
☐ Depression	☐ Diarrhea	☐ Heart Attack	☐ Low Back Pain
☐ Sleeping Problems	☐ Loss of Smell or Taste	☐ Stroke	☐ Pain in Legs or Feet
☐ Pain Worse at Night	☐ Fatigue	☐ Headaches	☐ Fever
☐ Tension	☐ Numbness in Legs or Feet	☐ Lights Bother Eyes	☐ Weight Loss
☐ Sinus Pain	☐ Numbness in Hands or Arms	☐ Cancer or Tumors	

☐ Other _____

HEALTH HISTORY

A. List any other previous major medical history or surgeries with dates:

_____

_____

_____

B. List any current medications, or provide a separate attachment:

_____

_____

_____

C. Do you have a pacemaker or defibrillator device implant? **Yes / No** Date of implant: _____ / _____ / _____

D. List any metal implants / joint replacements? _____

_____

_____