advanced physical therapy

creating an environment for wellness and healing

Medical History

Please identify details about the problem(s) which limit your function:

Date of Injury (if applicable): __/__/___

Chief Complaints

☐	instability
☐	numbness
☐	pain
☐	paresthesia (tingling/pins and needles)
☐	stiffness
☐	swelling
☐	weakness
☐	other

Have you had any falls, or near falls, in the last year? (Circle one, if yes, please explain).

No

Yes ____________________

____

Medications (list name and dosage)

____

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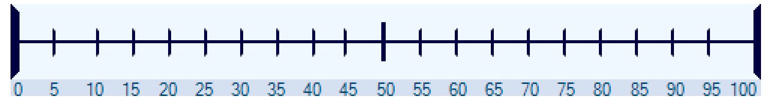
Region

☐	back
☐	chest
☐	head
☐	left lower extremity (hip/knee/foot/ankle)
☐	left upper extremity
☐	right lower extremity (hip/knee/foot/ankle)
☐	right upper extremity
☐	neck
☐	pelvis
☐	other

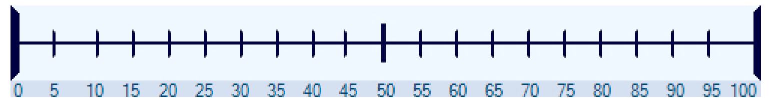
In the past year, have you had any of the following symptoms?

☐	abdominal pain	
☐	allergies (please list):	
☐	bowel problems	
☐	chest pain	
☐	depression	
☐	difficulty or changes in swallowing	
☐	difficulty sleeping	
☐	dizziness or blackouts	
☐	excessive thirst	
☐	fever/chills/sweats	
☐	foot pain/discoloration	
☐	frequent heartburn or indigestion	
☐	hearing problems	
☐	heart palpatations	
☐	joint pain, swelling, or redness	
☐	loss of appetite	
☐	loss of balance or falling	
☐	nausea/vomiting	
☐	numbness or changes in sensation	
☐	pain at night	
☐	pain or cramping in lower leg (calf)	
☐	prolonged fatigue	
☐	seizures	
☐	sexually transmitted disease	
☐	shortness of breath	
☐	unusual lumps or growths	
☐	unusual menstrual irregularities	
☐	urinary problems	
☐	vision problems (i.e. blurred vision or loss of sight)	
☐	other	

Frequency of Symptoms (Please rate the frequency of your symptoms on a scale of 0-100 where 0 is no occcurrence and 100 is constant occurrence by circling the line above the oppropriate number.)



Severityof Symptoms (Please rate the severity of your symptoms on a scale of 0-100 where 0 is no occcurrence and 100 is constant occurrence by circling the line above the oppropriate number.)



Please select any condition(s) (if applicable) for which immediate family member(s) has been diagnosed with (past or present)

	Relation	Age
cancer		
heart disease		
hypertension		
stroke		
diabetes		
arthritis		
obesity		
neurological condition		
autoimmune condition		
fibromyalgia		
other		