Orthopedic & Sport Rehabilitation, LLC
Patient History

Answer all questions to the best of your ability to assist your therapist with your care.

Name ____

Height ______FT ______IN Weight ________LBS Dominant Hand: Right Left

Referring Doctor (Name/Location) ____

Internist/Family Doctor (Name/Location) ____

HISTORY OF PRESENT ILLNESS

1. Chief Complaint (Why are you seeing us today?) ____________________________________
2. How long have you had this problem (Date Specific)? _________________________________
3. What started this problem? ____
4. Has the problem become worse? ☐ YES ☐ NO If Yes, Date_________
5. Is the problem the result of a car accident? ☐ YES ☐ NO If Yes, Date_________
6. Is the problem a result of a work accident? ☐ YES ☐ NO If Yes, Date_________

Signs associated with your problem:
(Check *all that apply)*

Sign	Location	Sign	Location
☐ Swelling/Edema	________________	☐ Muscles Atrophy	________________
☐ Redness/Warmth	________________	☐ Muscle Spasm/Twitch	________________
☐ Skin Changes/Bruising	________________	☐ Loss of Movement	________________
☐ Numbness/Tingling	________________	☐ Other	________________

Describe the quality of your pain? (*Check All That Apply)*

☐Sharp ☐ Stabbing ☐ Shooting ☐ Burning ☐ Aching
☐ Dull ☐ Throbbing ☐ Continuous ☐ Intermittent ☐ Other_________

Does anything make your problem better? ☐ **YES** ☐ **NO**

If yes, please list: ____

Rate your pain severity using the following scale: *(Check a number)*

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Treatments for your chief complaint have included: *(Check all that apply)*

☐ Physical Therapy	☐ NSAID Medication
☐ Occupational Therapy	☐ Ice/Heat
☐ Massage Therapy	☐ Pain Medication
☐ Chiropractic Treatments	☐ Other:___________________________

Tests done to evaluate your problem: ***(Check all that apply)***

Test	Area Tested	Date	Location
X-Rays			
CT Scan			
MRI			
Bone Scan			
EMG			

Current Symptoms: (*Check all that apply)*

☐ Fever	☐ Recent Weight Change	☐ Poor Circulation	☐ Chills
☐ Weakness of Extremities	☐ Very Low Energy	☐ Back Pain	☐ Currently Pregnant
☐ Frequent Headaches	☐ Dizziness	☐ Change in Bowel Function	☐ Heart/Chest Pain
☐ Poor Balance	☐ Change in Urine Function	☐ Abnormal Heart Beat	☐ Broken Bones
☐ Chest Pain with Breath	☐ Neck Pain	☐ Shortness of Breath	☐ Other__________________

Medical History (*Check all that apply)*

☐ Allergies	☐ Cardiac Pacemaker	☐ Emphysema	☐ Kidney Problems	☐ Thyroid Disease
☐ Anemia	☐ Chem. Dependency	☐ Bronchitis	☐ Metal Implants	☐ Tuberculosis
☐ Anxiety	☐ Circulation Issues	☐ Fractures	☐ Multiple Sclerosis	☐ Vision Problems
☐ Arthritis	☐ Currently Pregnant	☐ GallBladder Issues	☐ Osteoporosis	
☐ Asthma	☐ Depression	☐ Hepatitis	☐ Parkinsons	
☐ Cancer	☐ Diabetes	☐ High Blood Pressure	☐ Seizures	
☐ Cardiac Conditions	☐ Dizzy Spells	☐ Incontinence	☐ Strokes	

Describe any other conditions or precautions: ____

Surgical History:

Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:
Body Region:	Surgery Type:	Date:

Current Medications:

Drug Name:	Dosage:	Reason for Taking:
Drug Name:	Dosage:	Reason for Taking:
Drug Name:	Dosage:	Reason for Taking:
☐ ***I have provided a list of medications to the front desk.***		

Work Status: ☐ Part time Student ☐ Full time Student ☐ Employed

Marital Status: ☐ Single ☐ Married ☐ Other

My Signature confirms I have answered the above questions to the best of my ability.

Patient Signature: ____ Date ______________

(Parent/Guardian if under 18 years old)