Orthopedic & Sport Rehabilitation, LLC

PATIENT INFORMATION -This information is confidential

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? ____________________
3. What started the problem? ____________________

	Yes	No	When?
4. Has the problem become worse?	______	______	______
5. Is this problem the result of a car accident?	______	______	______
6. Is this problem the result of a work accident?	______	______	______

Signs associated with your problem: (C*ircle all that apply)*   None Apply

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

Describe the quality of your pain? ***Circle all that apply***   None Apply

Sharp	Stabbing	Shooting	Burning	Aching
Dull	Throbbing	Continuous	Intermittent	Other ______

Does anything make your problem better?   Yes   No

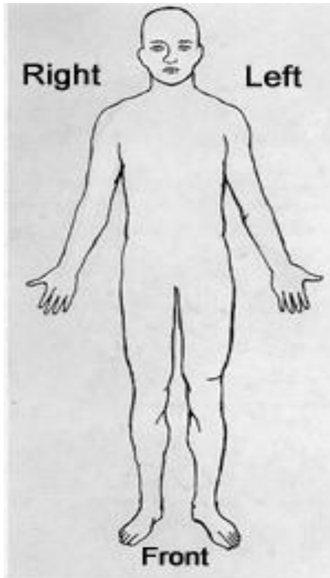
If yes, please list: ____________________________________

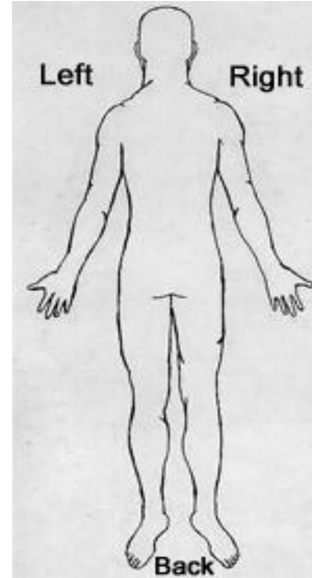
Rate your pain severity using the following scale: ***(Circle a number)***

1 2 3 4 5 6 7 8 9 10

Please CIRCLE where your pain is located. Does not apply

Please put an X where you are having numbness or tingling. Does not apply





Treatments for your chief complaint have included: ***(Check all that apply)*** None Apply

________	Physical Therapy	________	NSAID Medication
________	Occupational Therapy	________	Ice/Heat *(circle)*
________	Massage Therapy	________	Pain Medication
________	Chiropractic	________	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 arms/legs	________	Very low energy
________	Back pain	________	Currently pregnant	________	Frequent headaches
________	Dizziness	________	Change in bowel function	________	Heart or chest pain
________	Poor balance	________	Change in urine function	________	Abnormal heart beat
________	Broken bones	________	Chest pain with breath	________	Other ________
________	Neck pain	________	Short of breath with walking		

Patient Initials ________________

MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Allergies	O Yes	O No	Depression	O Yes	O No	Multiple Sclerosis	O Yes	O No
Anemia	O Yes	O No	Diabetes	O Yes	O No	Osteoporosis	O Yes	O No
Anxiety	O Yes	O No	Dizzy Spells	O Yes	O No	Parkinsons	O Yes	O No
Arthritis	O Yes	O No	Emphysema/Bronchitis	O Yes	O No	Rheumatoid Arthritis	O Yes	O No
Asthma	O Yes	O No	Fractures	O Yes	O No	Seizures	O Yes	O No
Cancer	O Yes	O No	Gallbladder Problems	O Yes	O No	Strokes	O Yes	O No
Cardiac Conditions	O Yes	O No	Hepatitis	O Yes	O No	Thyroid Disease	O Yes	O No
Cardiac Pacemaker	O Yes	O No	High Blood Pressure	O Yes	O No	Tuberculosis	O Yes	O No
Chemical Dependency	O Yes	O No	Incontinence	O Yes	O No	Vision Problems	O Yes	O No
Circulation Problems	O Yes	O No	Kidney Problems	O Yes	O No			
Currently Pregnant	O Yes	O No	Metal Implants	O Yes	O No			

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? O Yes O No Date of Fall:_________________________

Two or more falls in the last year? O Yes O No Dates of Falls:_______________________

Surgical History

Body Region: ____________________ Surgery Type: _______________________Date of Surgery:_____________

Body Region: ____________________ Surgery Type: _______________________Date of Surgery:_____________

Body Region: ____________________ Surgery Type: _______________________Date of Surgery:_____________

Body Region: ____________________ Surgery Type: _______________________Date of Surgery:_____________

Body Region: ____________________ Surgery Type: _______________________Date of Surgery:_____________

Current Medications

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

Drug: ________________________ Dosage: _________ Reason for Taking:______________________________

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)