

# Crossroads Physical Therapy

## Medical History

Patient's Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Please indicate your present medical status: illness, disease, pain, fracture:

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2. Please indicate your past history of health: illness, disease, pain, fracture:

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3. List all trauma and when it occurred. All trauma, accidents, and injuries are important, not just recent ones.

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4. List operations you have undergone with approximate dates:

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5. List all medications you are presently taking (and dosage):

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6. List all medications you have taken during the last 5 years:

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7. List specialists, doctors you have seen and approximate dates:

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8. How would you rate your current pain on a scale from 0-10 (0/10 = no pain; 10/10 = unbearable pain):

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### FUNCTION:

How many hours do you sleep at night? \_\_\_\_\_

How many hours per day (per 24 hours) do you spend out of bed? \_\_\_\_\_

Do you snore? Yes \_\_\_\_\_ No \_\_\_\_\_

How would you consider your present level of activity?

Poor \_\_\_\_\_ Fair \_\_\_\_\_ Good \_\_\_\_\_

Please list your present hobbies: \_\_\_\_\_

Describe any regular exercise or sport you presently do: \_\_\_\_\_

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Please indicate your ability with the following activities:

	Slightly Difficult	Great Difficulty	Slightly Painful	Severely Painful	Not Applicable
Lying on back					
Lying on stomach					
Lying on right side					
Lying on left side					
Turning over back to stomach					
Turning over stomach to back					
Kneeling					
Sitting in chair					
Sitting on sofa					
Sitting in car					
Driving					
Driving(reverse)					
Standing from floor					
Standing from bed					
Standing from chair					
Standing up straight					
Walking					
Running					
Bending (Vacuum)					
Lifting objects from floor					
Lifting objects from table					
Reaching over head					
Dressing/Undressing					
Bathroom/hygiene					
Sports					
Work					

History of Treatment:

Please indicate the method you have used to decrease your pain, by filling in how often used, and please rate the effectiveness on the following scale: (W = worse, 0 = no effect, 1 = little effect, 2 = fair, 3 = good, 4 = excellent):

	Never	Once a month	Once a week	Twice a week	Once a day	More than once a day
Medications						
Exercise						
Bed Rest						
Heat/cold						
Biofeedback, relaxation, imagery						
Physical Therapy						
Chiropractic						
Massage						
Individual psychotherapy						
Group psychotherapy						
Brace equipment						
TENS						
Ignore pain						

1. If the chart on the previous page was not sufficient to describe your method of pain control, please add detail:

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2. Symptoms – please check the following:

	Never	Mild/occasional	Moderate/often	Severe/constant
Dizziness				
Nausea				
Ringling ears, painful ears				
Vision: blurring, burning, aching, pressure, change in vision				
Decreased concentration/attention				
Short-term memory loss				
Allergies, sinus				
Cold/hands and feet				
Stiffness				
Balance/coordination problems				
Bowel/bladder problems				
Sexual function problems				

6. Please indicate what makes the pain worse: \_\_\_lying down \_\_\_sitting \_\_\_standing \_\_\_walking \_\_\_running \_\_\_driving \_\_\_working \_\_\_time of day \_\_\_too much acitivity \_\_\_bending \_\_\_reaching \_\_\_lifting \_\_\_squatting \_\_\_kneeling \_\_\_too little activity \_\_\_other(specify): \_\_\_\_\_

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7. What makes your pain decrease \_\_\_\_\_

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8. Was your onset of pain: \_\_\_Sudden? \_\_\_Gradual? Explain (if necessary): \_\_\_\_\_

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9. When did your pain begin (weeks – months – years): \_\_\_\_\_

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10. What do you feel needs to be done to begin your recovery? \_\_\_\_\_

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11. What are your goals from therapy? \_\_\_\_\_

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12. In your words, what do you feel is your primary problem? \_\_\_\_\_

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