ORLEANS Community Health

Patient History Form ☐Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

Name: _____ **(Maiden)** _____ **Date:** _____

Date of Birth: _____ **Place of Birth:** _____

Present Complaint: _____

When did your problem begin? (Specific date if possible) _____

How did you injure yourself? _____

How often are the complaints present?

☐ Constant (76 - 100%) ☐ Frequent (51 - 75%) ☐ Occasional (26 – 50%) ☐ Intermittent (25% or less)

How bad is your pain? Please circle a number.

Best 0 1 2 3 4 5 6 7 8 9 10 Worst

Since your problem began, is the pain: ☐ decreasing, ☐ increasing, ☐ not changing

What treatments/test have you received for this present condition?

☐ None ☐ Previous Physical Therapy ☐ Chiropractic ☐ Medications

☐ Surgery ☐ X-ray, MRI, CT scan ☐ Other: _____

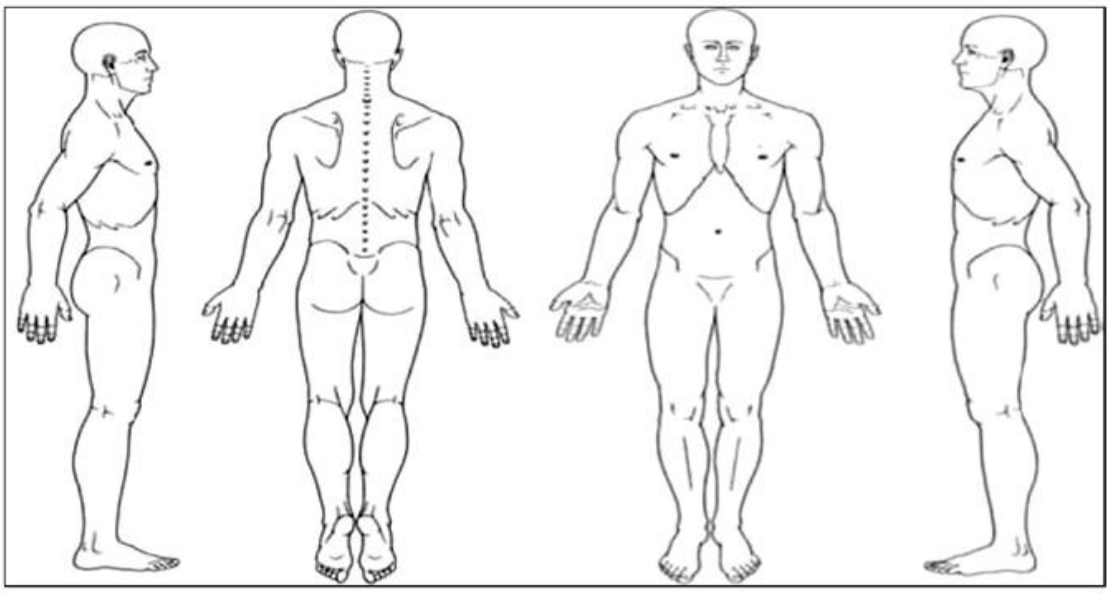
What makes your problem better? _____

What makes your problem worse? _____

How would you rate your general stress level? ☐ No Stress ☐ Moderate Stress ☐ Greatly Stressed

How would you describe your physical activity level at work? ☐ Mostly sitting ☐ Light ☐ Moderate ☐ Heavy

How would you describe your general physical activity level? ☐ Sedentary ☐ Light ☐ Strenuous



Please mark the pictures where you have symptoms

Please check any of the following that apply to you:

☐ Diabetes	☐ Dizziness	☐ Prostate Problems
☐ Arthritis	☐ Headaches	☐ Drug or Alcohol Dependence
☐ Kidney disorders	☐ Falls in last 6 months	☐ Raynaud's Syndrome
☐ Allergies	☐ Depression	☐ COPD
☐ Loss of bladder/bowel control	☐ High Blood Pressure	☐ GERD
☐ Fainting	☐ Angina	☐ I Smoke
☐ Visual disturbances	☐ Heart Attack	☐ I used to Smoke
☐ Nausea	☐ Stroke	☐ I use smokeless tobacco
☐ Asthma	☐ Cancer	☐ I used to use smokeless tobacco
☐ High Cholesterol	☐ Parkinson's	

☐ Other Health Conditions: _____

Please list any previous surgeries: _____

_____

Please list your medications: _____

_____

Is your case in current litigation? ☐ Yes ☐ No

Do you have a permanent disability rating? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer: _____

Employer's Address: _____

_____

Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Retired

Religion: _____

Ethnicity: ☐ Asian/Pacific Islander ☐ Black/African American ☐ Hispanic/Latino
☐ Native American/American Indian ☐ White ☐ Other

Military Status: ☐ Not affiliated ☐ Active ☐ Active Reserve ☐ Inactive Reserve
☐ ROTC ☐ Dependent ☐ Retired ☐ National Guard

What are your goals for physical therapy? _____

_____

_____

Signature Date

In Case of Emergency Contact: Name: _____

Relationship: _____ Phone Number: _____

Address: _____