PATIENT SELF-ASSESSMENT for PHYSICAL THERAPY

Today's date: ______ Age: ______ DOB: ______

Patient's Full Name: ______ Height: ______ Weight: ______

Primary Care Physician: ______ Dominant hand: [ ] right [ ] left

I was referred by:

PLEASE FILL OUT YOUR COMPLETE MEDICAL HISTORY

[ ] Heart Disease	[ ] Diabetes	[ ] Osteoporosis	[ ] Tuberculosis
[ ] High Blood Pressure	[ ] Hypoglycemia	[ ] Osteopenia	[ ] Seizures
[ ] Pacemaker	[ ] Asthma	[ ] Scoliosis	[ ] Kidney Problems
[ ] Stroke	[ ] Fractures	[ ] Fibromyalgia	[ ] Respiratory Disorder
[ ] Chest pain	[ ] Implants	[ ] HIV/AIDS	[ ] Heat/Cold Sensitivity
[ ] Cancer	[ ] Arthritis	[ ] Hepatitis	[ ] Latex Allergy

[ ] Other ______

Pregnant? Y___ N___ due date? ______

Do you smoke now? Y___ N___ how much? ______

Any other allergies? Y___ N___ ______

PLEASE LIST ALL PAST SURGERIES & APPROX. DATE (i.e. tonsils, appendix, etc.) [ ] NONE

______

______

______

PLEASE LIST ALL MEDS, DOSE & FREQUENCY [ ] SEE ATTACHED LIST [ ] NONE

______

______

______

Are you allergic to any medication? ______

PLEASE COMPLETE YOUR EMPLOYMENT HISTORY

Occupation? ______

Work status? [ ] light duty [ ] full duty [ ] not working

How many hours per week do you work? ______

What work duties/activities are the most difficult? ______

PLEASE STATE THE REASON YOU'VE BEEN REFERRED TO THERAPY

Describe your current problem: ______

What diagnostic tests have you had?	XRAYS?	Y___ N___	Results?	______
	MRI?	Y___ N___	Results?	______
	OTHER?	Y___ N___	Results?	______
What type of treatment have you had?	SURGERY?	Y___ N___	Results?	______
	PHYS THERAPY?	Y___ N___	Results?	______
	CHIROPRACTOR?	Y___ N___	Results?	______
	INJECTIONS?	Y___ N___	Results?	______
	OTHER?	Y___ N___	Results?	______

What do you hope to accomplish with therapy?

When is your next follow-up appointment with your doctor?

To the best of my knowledge, the information I have given is complete and true.

______

Patient signature *Date*