

CASE HISTORY

Name: _____ Date: _____ Age: _____

DESCRIPTION OF CURRENT CONDITION

Describe the problem (s) for which you seek therapy. Include dates when each problem or injury occurred:

When did this problem or injury first occur (date)? _____

Describe the activity you were doing at the time of injury: _____

Primary Complaint (circle all that apply)

- Pain Stiffness Weakness
 Loss of Function Swelling Other _____

What makes the problem worse? _____

Worse in: AM___ PM___ During the Day___ At Night/Sleeping___

What makes the problem better? _____

MEDICAL CARE/TESTING

Please list any other kind of health care professional you are seeing for this problem: _____

Have you undergone any of the following diagnostic tests?

- Bone Scan Blood Test Nerve Conduction Velocity, EMG
 CT Scan MRI X-Ray
 Ultrasound Doppler Cardiac Stress Test

Results from above tests _____

List the medications (including over the counter) and supplements you are presently taking: _____

PRIOR EPISODES

Have you ever had this problem before? Yes No If yes, when? _____

How many prior episodes? 0-5 6-10 more than 10

Is the severity Increasing Decreasing Unchanged

What treatments have you received, or are you currently receiving for THIS condition?

- Acupuncture Chiropractic Massage Therapy Physical Therapy
 Bed Rest Injections Medication Surgery
 Other

Date and description of Surgery related to this problem _____

Did the problem get better? _____

PAIN DESCRIPTION

Pain Frequency (Circle one):

- Constant (never goes away)
- Intermittent (comes and goes daily)
- Occasional (less than daily)
- Sporadic (less than weekly)

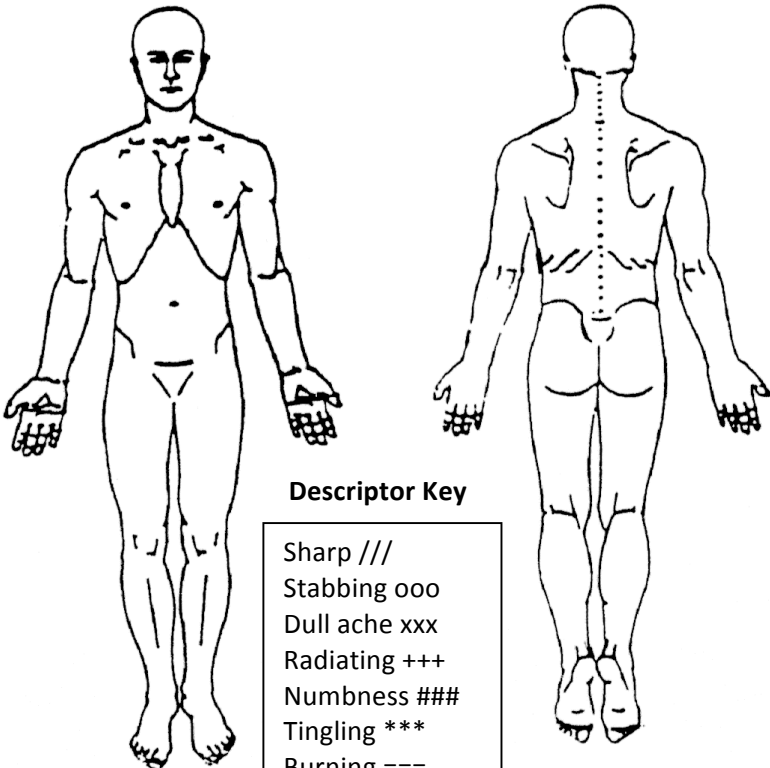
Pain Scale-Using the scale listed below please rate your pain level:

At Best: _____ At Worst: _____ Average: _____

- 0 No Pain
- 1 Mild pain; you are aware of it, but it doesn't bother you
- 2 Mild pain; you become more aware of it, but only begins to bother you
- 3 Moderate pain that you can tolerate without medication
- 4 More severe pain that requires medication to tolerate
- 5 Severe pain; you begin to feel antisocial
- 6 Severe pain; you cannot participate in recreational activities
- 7 Very severe pain; you cannot participate in activities of daily living
- 8 Intensely severe pain; you cannot leave the house
- 9 Extremely severe pain; you cannot get out of bed
- 10 Most severe pain; it may make you contemplate going to the Emergency Room

Please shade in areas of pain or discomfort on the body diagram and make comments to the side if necessary.

Right Left Left Right



Comments:

FUNCTIONAL STATUS AND LIMITATIONS

Occupation: _____

What is your work status?

- Full time
- Part time
- Retired
- Other
- Regular duty
- Restricted duty
- Unemployed

Previous Functional Level

- No limits with activities of daily living
- No limits with work activities
- No limits with recreational activities
- Other

Check status of daily activities

Transfer/Positions:	Difficulty	Unable	Comments/Problems
<input type="checkbox"/> Sit to Stand from Chair	_____	_____	_____
<input type="checkbox"/> Sit to lying	_____	_____	_____
<input type="checkbox"/> Lying to Sit	_____	_____	_____
<input type="checkbox"/> Lying	_____	_____	_____
<input type="checkbox"/> Rolling	_____	_____	_____
<input type="checkbox"/> Driving	_____	_____	_____
<input type="checkbox"/> Getting in and out of the car	_____	_____	_____

Housework

<input type="checkbox"/> Vacuuming, sweeping, mopping	_____	_____	_____
<input type="checkbox"/> Washing dishes, cooking	_____	_____	_____
<input type="checkbox"/> Making the bed, doing laundry	_____	_____	_____
<input type="checkbox"/> Gardening/yard work	_____	_____	_____
<input type="checkbox"/> Washing car	_____	_____	_____

Self Care

<input type="checkbox"/> Bathing, grooming	_____	_____	_____
<input type="checkbox"/> Dressing	_____	_____	_____

Other

<input type="checkbox"/> Reaching an object on the floor	_____	_____	_____
<input type="checkbox"/> Reaching an object overhead	_____	_____	_____
<input type="checkbox"/> Carrying groceries, computer bag	_____	_____	_____
<input type="checkbox"/> Ascending stairs or ramps	_____	_____	_____
<input type="checkbox"/> Descending stairs or ramps	_____	_____	_____
<input type="checkbox"/> Pinching/grasping	_____	_____	_____
<input type="checkbox"/> Computer Use	_____	_____	_____
<input type="checkbox"/> Balance/Falls	_____	_____	_____
<input type="checkbox"/> Lifting objects	_____	_____	_____
<input type="checkbox"/> Bending, kneeling, stooping	_____	_____	_____
<input type="checkbox"/> Twisting, rotating	_____	_____	_____
<input type="checkbox"/> Work specific Activity	_____	_____	_____
<input type="checkbox"/> Sport specific activity	_____	_____	_____
<input type="checkbox"/> Other	_____	_____	_____

Able to walk up to 5 ___ 10 ___ 20 ___ 30 ___ 45 ___ 60+ ___ Minutes
 Able to stand up to 5 ___ 10 ___ 20 ___ 30 ___ 45 ___ 60+ ___ Minutes
 Able to sit up to 5 ___ 10 ___ 20 ___ 30 ___ 45 ___ 60+ ___ Minutes

Sleeping pattern/problems Average length of nights sleep? _____ Hours
 Sleep is restful Yes ___ No ___ If No, describe _____

PAST MEDICAL HISTORY

Which of the following describes your overall health status?

- Excellent Good Fair Poor

Have you ever received treatment for any of the following injuries:

- Head Neck Ribs/mid back
 Shoulder Elbow Wrist/hand
 Back Abdomen Pelvis
 Hip Knee Foot/ankle
 Other _____

If yes, please describe: _____

Have you had any surgeries? Yes No If yes, please describe _____

Female only

Have you ever been or are you currently pregnant? Yes No If yes, how many pregnancies? _____
How many children? _____ Number of vaginal births: _____
Number of C sections: _____
Any complications? Please describe _____

Have you ever experienced any of the following?

- Recent Fever/Chills Unexplained Weight Loss
 Urinary or Fecal Incontinence Urgency with urination Straining with urination
 Pain with intercourse Pain with urinations/defecation
 Nausea/Vomiting Dizziness/Vertigo

Please check the following conditions you have experienced:

- Anemia Allergies Arthritis Asthma
 Blood Pressure(high/low) Blood Clots Cancer Congestive heart defect
 Depression Diabetes Difficulty swallowing Digestive problems
 Emphysema Epilepsy/seizures Fainting Falling/Balance issues
 Fatigue Glaucoma Gout Heart Disease
 Heart Attack Headaches Hemophilia Hepatitis
 HIV/AIDS Kidney Stones Kidney Infections Leukemia
 Lupus Liver Disease Loss of consciousness
 Night Sweats Osteoporosis/osteopenia Pacemaker/Defibrillator
Peripheral vascular disease Persistent cough Prostate problems Sciatica
 Scoliosis Sickle cell disease Shortness of breath Stroke
 Suicidal thoughts Thyroid problems TB Temperature Sensitivity
 Visual changes

Please list and describe all previous accidents and any other injuries, illnesses not listed above and include approximate dates: _____

WELL BEING/ACTIVITES

Stress Levels

My family None Minimal Moderate Severe _____
My relationship None Minimal Moderate Severe _____
My work None Minimal Moderate Severe Hours worked (wk): _____
My financial None Minimal Moderate Severe _____
My health None Minimal Moderate Severe _____
Other (list): _____ None Minimal Moderate Severe _____

Lifestyle: Sedentary Physically Active

How much time do you have for yourself to relax and what do you do to relax i.e. hobbies, sports, meditation, etc...? _____

Do you exercise or play a sport? And if so what kind and how often? _____

What position do you sleep in? (circle most frequent position) stomach , on your back, on your side

Age/Firmness of Mattress _____ Use Cervical Pillow _____

Describe current work activities: _____

Any recent changes in work setting or activities? No Yes If Yes, describe _____

Do you use a computer on a regular basis? No Yes If Yes, describe _____

Do you travel frequently? No Yes If Yes, describe _____

Any recent changes in shoes/orthotics or sporting equipment No Yes If Yes, describe _____

Activities you wish to return to? _____

Is there anything that might prevent you from properly following your therapy program? _____

Any other important information we should know about you or your condition? _____

What are your goals for physical therapy? _____

Therapist's comments: _____

Therapist's Signature: _____ Date: _____