

HOUGHTON PHYSICAL THERAPY AND SPORTS CONDITIONING

80 Park St. Attleboro, MA 02703
Phone: (508)223-2300 Fax: (508)223-2340

Patient's History of Current Injury/Illness
Mailing Address: P.O. Box 865
Attleboro, MA 02703

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status _____ # Children _____ Ages _____

Occupation: _____ R-handed _____ L-handed _____ Ht. _____ Wt. _____

Have you ever been a patient here before? Yes _____ No _____; If yes, for the _____ same or _____ different problem?

Please indicate for which body region you are seeking treatment:

___ Neck ___ Mid Back ___ Low Back ___ Shoulder ___ Elbow ___ Hand/wrist ___ Hip ___ Knee ___ Ankle/foot ___ Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes _____ No _____

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes _____ No _____ If yes, when? _____

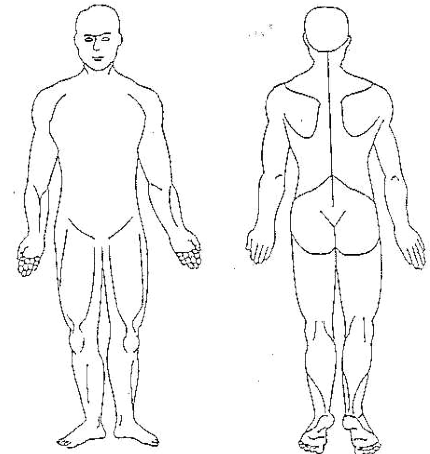
Have you recently had the following tests? Yes _____ No _____ If yes, check all that apply:

___ x-rays ___ Bone Scan ___ Myelogram ___ EKG
___ CT Scan ___ EMG ___ Stress Test ___ Echocardiogram
___ MRI ___ Blood Tests ___ Pulmonary Function Test ___ Other (Please list) _____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10
Pain free *Unconscious Pain*

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)



Is the pain there all the time (constant)? Yes _____ No _____

Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

Please use the body diagram above and **Shade Areas of Pain**

Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes _____ No _____

Describe _____

What activities/positions make your pain worse? _____

What activities/positions make your pain better? _____

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Have you **previously** seen any other health care provider for this problem? ___ Yes ___ No

___Physician ___Osteopath ___Podiatrist ___Other (Please list below)
 ___Physical Therapist ___Chiropractor ___Dentist _____

Are you currently seeing any other health care provider for this condition? ___ Yes ___ No; If Yes, please list:

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ___ If yes, please describe: _____

Please **circle** those treatments listed below that have been tried in the past:

___ Physical Therapy ___ Chiropractic ___ Acupuncture ___ Braces ___ Collars ___ Tens Unit ___ Injections
 ___ Medications ___ None ___ Other (please describe): _____

RATING SCALE: For each activity listed below, please rate your ability using the ability scale (or mark not-applicable) and pain level (if any) using the pain scale (0-10) on the previous page:

1- Able to do without difficulty	2- Able to do with little difficulty	3- Able to do with moderate difficulty	4- Able to do with much difficulty	5- Unable to do
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Activity/Function/Skill	Ability	Pain Level	Prior Level of Function (Before Illness/Injury)	N/A
Rolling over in bed				
Transfer to/from bed				
Transfer to/from bath				
Bathing				
Dressing				
Grooming				
Balancing				
Sitting				
Kneeling				
Stooping/squatting/bending				
Standing				
Walking				
Stair climbing				
Lifting				
Reaching- level/overhead				
Carrying				
Transfer to/from car				
Driving				
Using telephone				
Meal preparation				
Household cleaning				
List Other Activities Affected by your symptoms (i.e. sports, hobbies, etc.)				