**Patient Information/Medical History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birthdate\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do we have your permission to to text and/or email appointment reminders? 𑂽 Yes 𑂽 No

Primary Care Physician, Specialist(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Recreational activities:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Briefly describe the current problem you would like addressed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What date did your current symptoms start:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was your first episode of symptoms related to a specific incident? 𑂽 Yes 𑂽 No

If yes, please describe and specify date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms worse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your symptoms better:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had treatment for these symptoms before? 𑂽 Yes 𑂽 No

If yes, please specify type of treatment\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Using the 0 to 10 scale (0=no pain, 10= excruciating, worst pain imaginable), rate your pain using the last

7 days as reference: Currently:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Worst:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Best:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of your last doctor visit:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What tests were performed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SInce the onset of your current symptoms**, have you had any of the following:

𑂽 Fever/chills 𑂽 Malaise (unexplained tiredness)

𑂽 Unexplained weight change 𑂽 Unexplained muscle weakness

𑂽 Dizziness or fainting 𑂽 Night pain/sweats

𑂽 Change in bowel or bladder function 𑂽 Numbness/tingling

𑂽 Nausea/vomiting 𑂽 Constipation

𑂽 Diarrhea 𑂽 Cough

𑂽 Other (please describe):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you EVER** had any of the following:

𑂽 Cancer 𑂽 Stroke 𑂽 Emphysema/chronic bronchitis

𑂽 Heart problems 𑂽 Epilepsy/seizures 𑂽 Asthma

𑂽 High Blood Pressure 𑂽 Multiple sclerosis 𑂽 Allergies-list below

𑂽 Ankle swelling 𑂽 Head Injury 𑂽 Latex sensitivity

𑂽 Anemia 𑂽 Osteoporosis 𑂽 Hypothyroid/ Hyperthyroid

𑂽 Low back pain 𑂽 Chronic Fatigue Syndrome 𑂽 Headaches

𑂽 Sacroiliac/Tailbone pain 𑂽 Fibromyalgia 𑂽 Diabetes

𑂽 Alcoholism/Drug problem 𑂽 Arthritic conditions 𑂽 Kidney disease

𑂽 Childhood bladder problems 𑂽 Stress fracture 𑂽 Irritable Bowel Syndrome

𑂽 Depression 𑂽 Rheumatoid Arthritis 𑂽 Hepatitis

𑂽 Anorexia/bulimia 𑂽 Joint Replacement 𑂽 Sexually transmitted disease

𑂽 Smoking history 𑂽 Thyroid disorder 𑂽 Physical or Sexual abuse

𑂽 Vision/eye problems 𑂽 Sports Injuries 𑂽 Raynaud’s (cold hands and feet)

𑂽 Hearing loss/problems 𑂽 TMJ/ neck pain 𑂽 Pelvic pain

𑂽 HIV/AIDS 𑂽 Blood clots 𑂽 Lung Problems

𑂽 Bladder/urinary tract infection 𑂽 Other/Describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OB/Gyn History:**

Pregnancies #\_\_\_\_\_\_\_ Vaginal deliveries #\_\_\_\_\_\_\_\_ Episiotomies #\_\_\_\_\_\_\_\_ C-sections #\_\_\_\_\_\_\_\_

𑂽 Yes 𑂽 No Prolapse or organs falling out 𑂽 Yes 𑂽 No Menopause

𑂽 Yes 𑂽 No Vaginal dryness 𑂽 Yes 𑂽 No Painful vaginal penetration

𑂽 Yes 𑂽 No Painful periods 𑂽 Yes 𑂽 No Pelvic Pain

Please list any surgeries, or other conditions for which you have been hospitalized, including dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What is your personal goal for physical therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_