

# New Motion

Physical Therapy

## PATIENT HISTORY

Name \_\_\_\_\_

Age \_\_\_\_\_ Today's Date \_\_\_\_\_

1. What is the primary problem? \_\_\_\_\_  
 \_\_\_\_\_

2. Do you have any secondary problems? \_\_\_\_\_  
 \_\_\_\_\_

3. How did pain start? (Check all that apply).

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> - Suddenly  | <input type="checkbox"/> - Injured at work   |
| <input type="checkbox"/> - Gradually | <input type="checkbox"/> - Auto Accident     |
| <input type="checkbox"/> - Lifting   | <input type="checkbox"/> - No apparent cause |
| <input type="checkbox"/> - Pulling   | <input type="checkbox"/> - Fall              |
| <input type="checkbox"/> - Twisting  | <input type="checkbox"/> - Surgery           |

Additional Explanation: \_\_\_\_\_  
 \_\_\_\_\_

4. When did your problem begin? \_\_\_\_\_

(Date)

5. Since the onset, has your problem gotten:

- Worse     Better     Stayed the same

6. Have you ever had a similar problem in the past?

- No     Yes    When \_\_\_\_\_

7. Prior to this onset, were you free of symptoms?

- No     Yes

8. What other types of doctors or health care providers have you seen for this condition? \_\_\_\_\_  
 \_\_\_\_\_

9. What, if any, treatments have you had for this current problem? \_\_\_\_\_  
 \_\_\_\_\_

10. Have you had any of these diagnostic studies for your current problem?

(Check all that apply)

	Yes	No	Date
Diagnostic x-rays	<input type="checkbox"/>	<input type="checkbox"/>	_____
CT (computed tomography) scan	<input type="checkbox"/>	<input type="checkbox"/>	_____
Myelogram (x-ray w/dye inject.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Discogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
MRI (magnetic resonance imaging)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthrogram or sonogram	<input type="checkbox"/>	<input type="checkbox"/>	_____
Injections	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other			_____

11. What activities decrease the pain? (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Lying down                    | <input type="checkbox"/> Pain pills                         |
| <input type="checkbox"/> Sitting                       | <input type="checkbox"/> Manipulation                       |
| <input type="checkbox"/> Standing                      | <input type="checkbox"/> Injections for pain                |
| <input type="checkbox"/> Walking                       | <input type="checkbox"/> Muscle relaxant pills              |
| <input type="checkbox"/> Heat                          | <input type="checkbox"/> Aspirin or anti-inflammatory pills |
| <input type="checkbox"/> Cold                          | <input type="checkbox"/> Nothing                            |
| <input type="checkbox"/> Exercises in physical Therapy | <input type="checkbox"/> Other _____                        |

12. What activities increase the pain? (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Bending forward  |
| <input type="checkbox"/> Exercise (after)  | <input type="checkbox"/> Bending backward |
| <input type="checkbox"/> Sitting           | <input type="checkbox"/> Coughing         |
| <input type="checkbox"/> Standing          | <input type="checkbox"/> Sneezing         |
| <input type="checkbox"/> Heat              | <input type="checkbox"/> Walking          |
| <input type="checkbox"/> Cold              | <input type="checkbox"/> Other _____      |

13. Can you get comfortable at night?

- No     Yes     Sometimes

14. How do you feel upon rising?

- Fine     Stiff     Sore     Same

15. Once you begin moving about, does it:

- Worsen     Ease     Stay the same

16. What is it like at the end of the day?

- Worse     Better     Same

17. Are you taking any medications for this problem?

- No     Yes    If yes, list \_\_\_\_\_

18. Are you taking any other medications? \_\_\_\_\_  
 \_\_\_\_\_

19. Do you have any other conditions? (check all that apply)

- |  |   |
|--|---|
| <input type="checkbox"/> Stomach problems    | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Heart                  |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Epilepsy               |
| <input type="checkbox"/> Gout                | <input type="checkbox"/> Weight loss            |
| <input type="checkbox"/> Sexual Difficulties | <input type="checkbox"/> Pregnancy              |
| <input type="checkbox"/> Bowel or bladder    | <input type="checkbox"/> Other (please explain) |

20. Do you have any allergies?

- Yes     No    Please List: \_\_\_\_\_

21. What is your occupation? \_\_\_\_\_  
 \_\_\_\_\_

22. Are you working now?     No     Yes  
 If no, is it because of this problem     No     Yes  
 When was your last working day? \_\_\_\_\_

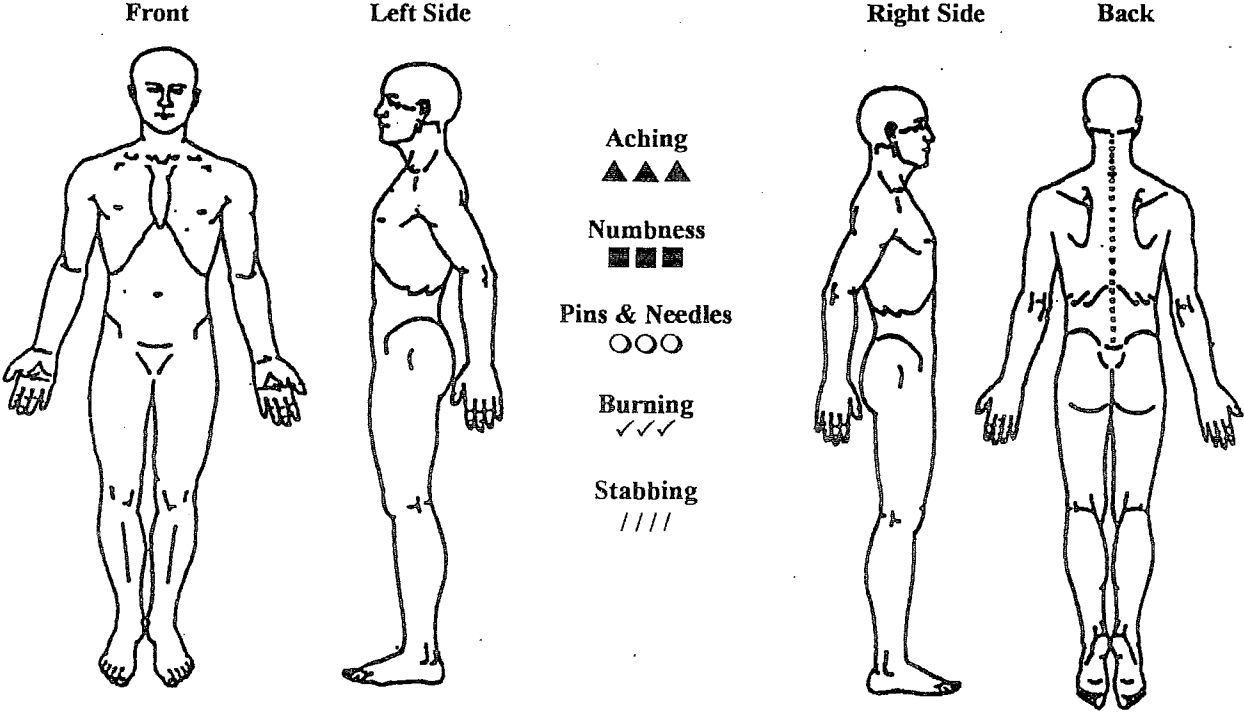
23. Please list your hobbies and interests: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

24. What is the quality of the pain? (check all that apply)

<input type="checkbox"/> Sharp	<input type="checkbox"/> Burning
<input type="checkbox"/> Cramp	<input type="checkbox"/> Dull
<input type="checkbox"/> Shooting	<input type="checkbox"/> Achy
<input type="checkbox"/> Throbbing	<input type="checkbox"/> All of the above
<input type="checkbox"/> Other _____	

25. On a scale of 1 to 10, how would you rate your pain?  
 (1 being no pain, 10 being the most painful) \_\_\_\_\_

26. Using the diagram below, mark the areas on your body where you feel the sensations described below. Using the appropriate symbol, mark the areas of radiating pain, and include all affected areas. Please mark an "X" on the body diagrams for where the pain is worst now.



27. For each of the following activities, place a check in the box "No / Not Well? If you have difficulty performing the activity due to your current symptoms. If the box has been checked, use the rating scale below and indicate how important it is to perform better on this activity as a result of therapy.

Ratings: (1) Not at all important, (2) Somewhat important, (3) Moderately important, (4) Very important (5) Extremely important

Activity / Functional Skill	Can Perform			Activity / Functional Skill	Can Perform		
	No	Not Well	Rating		No	Not Well	Rating
Sitting for up to _____ mins / hr	<input type="checkbox"/>	<input type="checkbox"/>	_____	Running / jogging _____ ft / mi	<input type="checkbox"/>	<input type="checkbox"/>	_____
Standing for up to _____ mins / hr	<input type="checkbox"/>	<input type="checkbox"/>	_____	Lifting - up to _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Moving from sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	_____	Carrying - up to _____ lbs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stairs - ascending / descending	<input type="checkbox"/>	<input type="checkbox"/>	_____	Reaching - behind / overhead	<input type="checkbox"/>	<input type="checkbox"/>	_____
Driving for up to _____ mins / hr	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stooping / squatting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Walk for up to _____ mins / hr	<input type="checkbox"/>	<input type="checkbox"/>	_____	Balancing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bending over	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dressing / grooming	<input type="checkbox"/>	<input type="checkbox"/>	_____
Climbing ladders	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing / pulling	<input type="checkbox"/>	<input type="checkbox"/>	_____	Managing children	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sleeping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jumping	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

28. Do you have any additional information that would be useful? \_\_\_\_\_