Patient History Admission Form

Patient Name _____ **Date of Initial Eval** _____

Email Address_____ **HIPAA Password** _____

Date of Referring Physician ***NEXT follow up Appt*** **for this diagnosis**_____

Please fill out all that apply to you and your current condition. Leave all blank that do not apply.

Subjective:

Current Condition:

Chief Complaint:

Provide in your words what brought you to therapy

Onset date: (1 week, 1 month)

Type of injury: **ie:** (auto accident, other)

Specific Injury:

Surgery Date: Yes No. Type of surgery:_____

Occupation:

Treatment Related to Condition

Test or Treatment R/T current condition	Date Done	Outcome

Comments:

Pain History

Pain Levels **(0 – 1 – 2 – 3 – 4 - 5 – 6 - 7 - 8 – 9 – 10 over 10)**

Pain Area:

Area	*Current Pain level*	*Best pain level*	*Worse Pain level*
IE (Shoulder)			

Pain Description:

Affected Area		*Activity/Time*	*Symptoms*	*Description*
IE (Shoulder)		Lifting/reaching	Increased/worsened	Burning/radiating/stabbing

Please add the information in boxes above.

List Activities that affect the symptoms above:

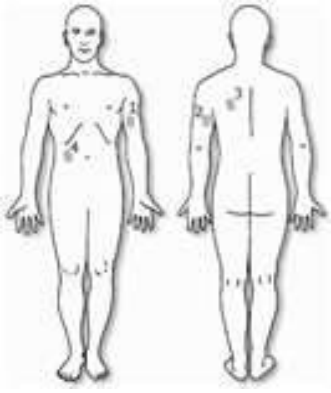
Bending, Reaching, Sitting, Standing, Laying, Lifting, Running, Twisting, Working

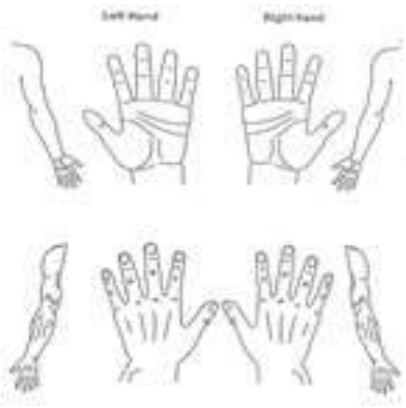
List Time in box above:

Morning, Noon, Evening, Night

List ALL words that describe your condition and mark on the figure below location:

Aching, Burning, Deep, Dull, Radiating , Sharp, Stabbing, Stiff, Throbbing





Comments:

Is this work related? Yes No **Do you have restrictions?** Yes No

Are you currently on Light Duty? Yes No **Are you on Modified Duty?** Yes No

If *not* currently working due to work injury, when was your last day worked

Comments:

Currently working? Yes No

Employer? ***Type of work do you perform***

Work Restrictions

Comments:

Functional Status:

Note the following table id for you the patient to fill out. Please address ALL areas apply to you that is a concern for you that you would like to address in therapy.

Functional Activity Limitation	**Status**	**Level of Limitation**	**Pt's Goal**	**Information**
ie) ADLs Activities of daily living):Bathing, Dressing, eating, grooming toileting Other:	Currently concern	can't perform	Yes	No pain/limitation w/ walking dog, riding bike

Medical History:

Surgical History: *Add surgeries ONLY that apply to reason you have come to therapy.*
If none applies Check; Patient is healthy and denies any surgical history. _____

Surgery	Date	Outcome	Status (current/discharged)

Below add the PHYSICIAN that did surgery, when was your LAST appointment with the Physician and when is your NEXT Follow up apt with Physician?

Medical Conditions: **List all conditions that you are CURRENTY being treated for that would have any impact on your recovery in therapy. (Asthma, Cardiac, Diabetes, Cancer, etc)**
If none applies Check; Patient denies any history of illness. _____

Medical Condition	Onset	Current Status	Precautions	Contraindications

Medication History:

List (or provide list) the names of the medication you're currently taking.

If none applies check: Patient is not currently taking any medications. _____

Medication:	*Dosage:*	*Prescription/Over the Counter:*

Comments:

NOTE: Tell therapist when you took dose of PAIN meds before coming in for therapy.
Therapist will ask you what your pain level is each time you come into therapy. It is IMPORTANT that you report your pain level and if you recently had taken a dose of medication/type of medication and when you last took medication.