Stony Brook Medicine

OUTPATIENT PHYSICAL THERAPY HISTORY FORM DATE: _____

SOCIAL HISTORY:

Date of birth: _____ Age_____ Circle one: Male/ Female Occupation: _____
If retired please indicate former occupation_____
Leisure Activities/Sports and frequency
played_____
_____

Tobacco: packs per day: present_____ past_____ .
Alcohol consumption:_____drinks per day/week/month (circle one)

HISTORY OF PRESENT ILLNESS:

What problem brings you to Physical Therapy today? _____
_____

When did this problem begin? (specific date if known)_____

Did this problem begin gradually or suddenly? Please describe. _____
_____
_

Have you had surgery for this condition? No___Yes____.

If you have had surgery please indicate Date_____Type of surgery_____

Facility where you had surgery_____Name of surgeon_____

Since this problem began your symptoms have : □ **improved** □ **worsened** □ **stayed the same.**
Please describe_____

How does this problem effect your functional ability at home and at work? _____
_____
_

How does this problem effect your recreation and/or leisure activities?_____
_____
_

Grade your pain level: at rest: 0------1-------2-------3-------4-------5-------6-------7-------8-------9-------10
Painfree Most Pain

With movement: 0------1-------2-------3-------4-------5-------6-------7-------8-------9-------1
Painfree Most Pain
Where is your pain?_____

Describe your pain □ sharp □ dull □ throbbing □ shooting □ burning □ tingling □ numbness □ other_____

How often do you have pain?
□ constant 76-100% of the time □ frequent 51-75% □ occasional 26-50% □ intermittent less than 25%

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What diagnostic tests/procedures have you undergone for this problem? (i.e., x-rays, EKG, MRI, CT scan).
Please list dates and results._____
_____

Have you received treatment for this condition in the past?_____

If yes, please indicate type and date of treatment. □ PT □ OT □ chiropractic □ MD □
Other_____

Dates of treatment_____

Are you taking any medications for this condition? _____If yes, please list them_____
_____

Please list any other medications you are taking_____
_____
_

PAST MEDICAL HISTORY

PAST	PRESENT	Condition	PAST	PRESENT	Condition
□	□	High Blood Pressure	□	□	Heart condition
□	□	Stroke	□	□	Diabetes
□	□	Seizure disorder	□	□	Arthritis
□	□	HIV	□	□	Kidney disease
□	□	Hepatitis	□	□	Migraines/ Headache
□	□	Lung disease	□	□	Cancer Location:_____
□	□	Pregnancy	Are you presently pregnant?		yes no n/a

List any allergies_____

Other Medical Conditions not noted above (i.e., surgeries, previous injuries, etc.): _____
_____

PATIENT'S GOALS FOR PHYSICAL THERAPY:

What do you hope to accomplish by attending physical therapy?_____
_____

Patient Signature: _____Date:_____
Patient Representative _____Relationship_____Date_____

For therapist use only □ smoking cessation advice/ second hand smoke information given to patient
_____
_____
_____
_____
_____
_____

Above report reviewed for accuracy with patient.