Absolute
Physical Therapy

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PATIENT HISTORY FORM

Thank you for providing the following important information to help us help you. Please let us know if you have any questions

Patient's Name:_____ Date of Birth:_____ Height_____ Weight _____

Describe your symptoms: _____

_____

When did symptoms begin _____Was there a surgery: _____Date_____

How did your symptoms begin: _____

Any falls this year with injury_____

Pain 0/10: Best_____ Average Daily_____Worst _____

What makes your symptoms worse: _____

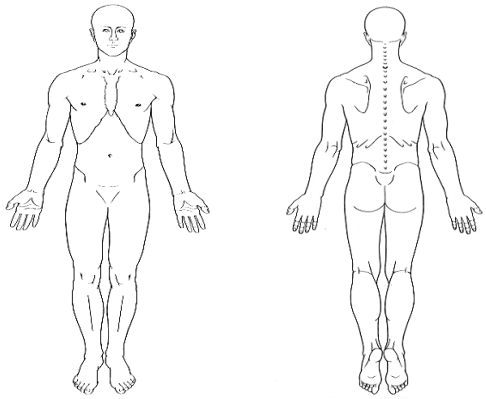
What makes your symptoms better: _____

What treatments have you received: _____

Please mark the diagram to show us your problem areas using these symbols:

NT Numbness/Tingling
A Ache
B Burning
S Sharp
D Dull

Also number the order of importance (1, 2, etc.) next to each area (#1 the most problematic).



INSTRUCTIONS: Put √ in those boxes applicable to you and in the "yes" or "no" space. If lines are provided, write in your answer.

Have you ever had	No	Yes	Please List	Have you ever had	No	Yes	Please List
Cancer				Rheumatoid condition			
Diabetes				Infectious Disease			
Stroke				Thyroid Condition			
Chest pain				Other Surgery			
Pacemaker/defibrillator							

Allergies: _____

Medications: _____