Seawolf Physical Therapy

Patient History/Self Assessment

Date: _____

Patient Name:_____ DOB:_____ Height:_____ Weight:_____

MEDICAL HISTORY/SUMMARY LIST:

Diabetes	Y/N	Stroke	Y/N	Unexplained Weight loss/gain	Y/N
Breathing Difficulties	Y/N	Heart Trouble	Y/N	Cancer	Y/N
Arthritis/Gout	Y/N	Fractures	Y/N	Numbness/Tingling	Y/N
High Blood Pressure	Y/N	Depression	Y/N	Tape allergy	Y/N
Tobacco Use	Y/N	Osteoporosis	Y/N	Adverse response to needles?	Y/N

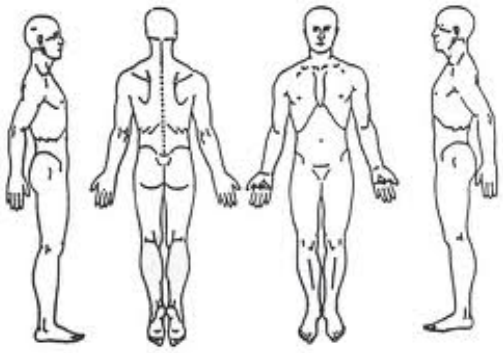
Other:_____

Surgeries/Injections:_____

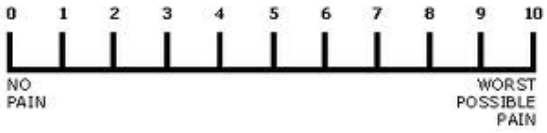
Medications:_____

Allergies:_____

1. When did your symptoms begin? _____
2. Date of surgery (if applicable):_____
3. Have you had X-rays, CT scans, or MRI?_____ If yes, when?_____
   Results: _____
4. Mark where your pain/symptoms are on the diagram below:



5. How bad is your pain today?



6. What makes symptoms worse? _____
7. What makes symptoms better? _____
8. Work /home restrictions due to condition?_____
9. What treatments have you tried?_____
10. Hobbies/recreation: _____

Seawolf Physical Therapy

Patient History/Self Assessment

What goals do you have for therapy? _____

Extra space for other pertinent information: _____