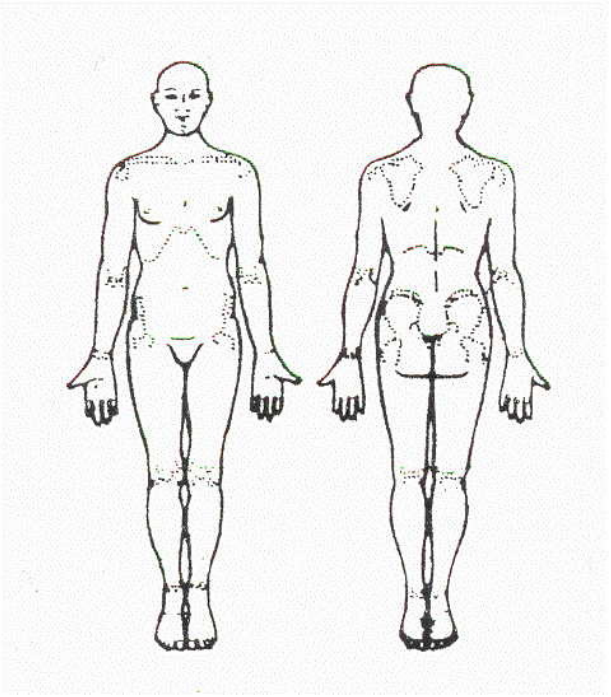
Broadway Physical Therapy & Sports Rehabilitation, LLC

Patient History



Name:_____ Email:_____

Age:_____ Occupation:_____ Presently working? Y N

Activities/Exercise Routine_____

Current Condition:

1. What major complaint, symptom or problem brings you here?

_____

2. What activities aggravate your condition?

_____

3. What relieves your symptoms?

_____

4. Progression of current condition (circle one): better worse same

5. Please rate your pain on a scale of 0-10: (circle one)

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Please shade areas of pain in above picture.
Circle all that apply:

Aching	Numbness
Sharp	Tingling
Dull	Shooting
Only with movement	

6. What tests/and or treatment have you had performed for this problem?_____

7. What medications are you taking for this problem?_____

Other Medications?_____

8. Past Medical History: Have you been diagnosed with or experienced any of the following?:

Allergy	Numbness
Balance	Neurologic condition
Bowel/Bladder Problems	Osteoarthritis
Cancer Type_____	Osteoporosis
Cardiac condition	Psychological condition
Chemical dependency	Respiratory
Diabetes	Rheumatoid Arthritis
Dizziness	Seizures
Gastrointestinal	Thyroid
Headaches/Migraines	Weakness
Hypertension	Other_____

9. To what extent are your daily activities limited?

(circle one) Mild Moderate Severe

10. What are your goals for coming to therapy?

Therapist's Notes: