Solutions PHYSICAL THERAPY

Keith E. Johnson PT, MTC, COMT
2704 Alexander Dr Suite G, Jonesboro, AR 72041
office: (870) 336-0262 fax: (870) 336-0264

Patient Medical History:

Last Name:	First Name:	Birthday: MM / DD / YY	Age:
Referring Physician:		Next Doctor's Appointment: MM / DD / YY	
Doctor's Diagnosis:			
Your main concern today:			

What is / was your occupation?

_____

- Are you presently working? YES NO
- Is the injury work related? YES NO
- Is injury result of auto accident? YES NO
- Is there an attorney involved? YES NO
- Are you receiving home health? YES NO
- Have you received any out-patient physical therapy this calendar year? YES NO

If "yes" how many visits? _____

Currently under care (select all that apply):

- ☐ Physical Therapist
- ☐ Chiropractor
- ☐ Psychiatrist / Psychologist
- ☐ Medical Doctor / Osteopath
- ☐ Other(s) _____

Tests done for **current** condition (list date):

- ☐ X-Ray _____
- ☐ MRI _____
- ☐ CAT Scan _____
- ☐ Bone Scan _____
- ☐ Nerve / Muscle _____
- ☐ Other(s) _____

Please list any past surgeries / conditions / hospitalizations and the dates associated:

_____

_____

_____

_____

_____

_____

_____

During the past month, have you been feeling down, depressed, or feeling hopeless? YES NO
During the past month, have you been bothered by sensing a lack of motivation? YES NO
How many days per week do you drink alcohol? _____
If one drink = one beer or glass of wine, how much do you drink per sitting on average? _____

FALL RISK

Have you had a fall in the last year? YES NO If so, how many in the past year? _____
If you had a fall in the past year, was an injury sustained? YES NO
If so, please describe the injury here: _____

THERAPISTS: If screen indicates potential fall risk, please include in your exam components demonstrating balance, strength, and gait training instructions.

WOMEN ONLY: Are you currently pregnant or think you might be pregnant? YES NO

Solutions PHYSICAL THERAPY

Keith E. Johnson PT, MTC, COMT
2704 Alexander Dr Suite G, Jonesboro, AR 72041
office: (870) 336-0262 fax: (870) 336-0264

Patient Medical History Continued:

Which of the following **over-the-counter** medications have you taken in the past week?

☐ Aspirin ☐ Tylenol ☐ Advil / Motrin / Ibuprofen

☐ Antihistamine ☐ Antacid ☐ Vitamins / Mineral Supplements

☐ Laxative ☐ Decongestant ☐ Herbals _____

Please list any **prescription** medications you are currently taking (pills / injections / patches):

_____

_____

If you have **ever** been diagnosed with any of the following conditions, please circle all that apply:

Seizures / Epilepsy	Cancer	Diabetes	Vision / Hearing Problems	Headaches
Osteoporosis	Stroke / TIAs	High Blood Pressure	Heart Problems	Pacemaker
Rheumatoid Arthritis	Hepatitis A, B or C	Anemia	Tuberculosis	Alzheimer's
Circulation Problems	Sleeping Problems	Depression	Weight / Energy Loss	Asthma
Emphysema / Bronchitis	Parkinson's	Chemical Dependency	Thyroid Problems	Multiple Sclerosis
Gout	Dehydration	Orthopedic Surgery	Urinary / Fecal Incontinence	

Have you recently noted any of the following?

Weight loss / gain?	YES	NO	Muscle weakness?	YES	NO
Nausea / vomiting?	YES	NO	Fever / chills / sweats?	YES	NO
Feeling dizzy / light headed?	YES	NO	Numbness / tingling?	YES	NO
Fatigue?	YES	NO	Night pain?	YES	NO

Please indicate your goals for physical therapy:

_____

_____

Please rank your current pain on a scale from 0-10, zero being pain free, ten being the worst pain:

0 1 2 3 4 5 6 7 8 9 10

What aggravates your pain? ☐ Sitting ☐ Rise from sitting ☐ Standing ☐ Lying down ☐ Overhead activity ☐ Lifting

☐ Bending ☐ Walking ☐ Running ☐ Going up stairs ☐ Going down stairs ☐ Squatting ☐ Dressing ☐ Stress

☐ Cough / Sneeze ☐ Turning head ☐ Driving ☐ Looking up ☐ Looking down ☐ Other: _____

What eases your pain? ☐ Rest ☐ Ice ☐ Heat ☐ Changing positions ☐ Medications ☐ Other: _____

Solutions PHYSICAL THERAPY

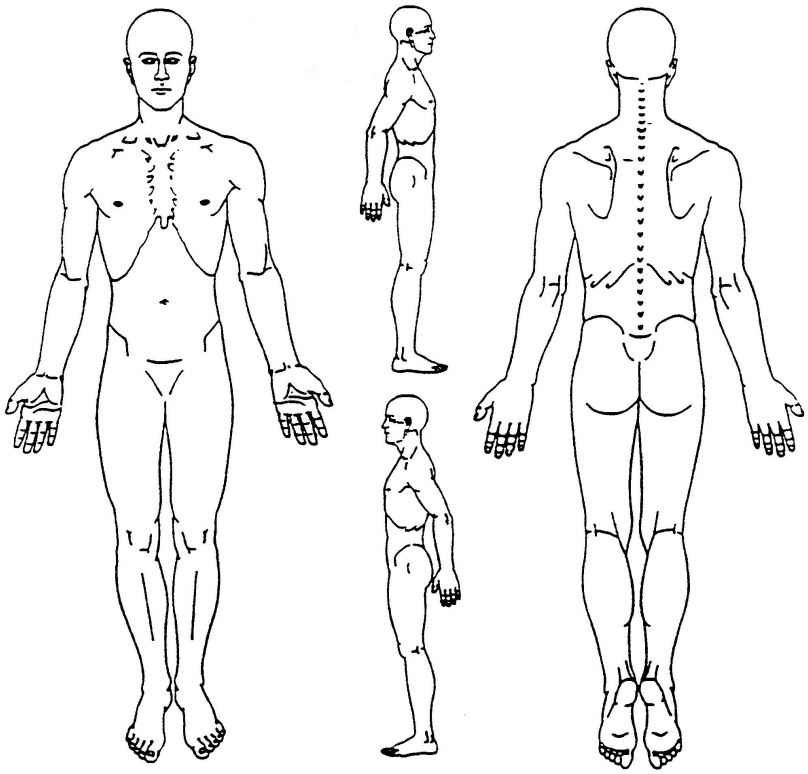
Keith E. Johnson PT, MTC, COMT
2704 Alexander Dr Suite G, Jonesboro, AR 72041
office: (870) 336-0262 fax: (870) 336-0264

Patient Medical History Continued:

Please use the diagram below to communicate to us where your pain is right now.

Mark all pain that you currently feel using the following marks:

Ache	Burning	Pins & Needles	Throbbing	Other / General Pain
^^^^^^^^	========	00000000	///////////////	XXXXXXXXX
^^^^^^^^	========	00000000	///////////////	XXXXXXXXX



I do hereby state that the information provided is accurate and true to the best of my knowledge.

_____ _____

Signature of patient or guardian Date

_____

If guardian, please list relationship to patient.

Therapist Use Only

Reviewed by Therapist: _____ Date: _____