GEER PHYSICAL THERAPY
Patient History Form

Name: _____ Date:_____ Age: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ falls
- ❑ changes in memory or orientation
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ recent infection (UTI, pneumonia, etc.)
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches
- ❑ Chest pain

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism) or IV drug use
- ❑ Disorders that affect your immune system
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ Peripheral neuropathy
- ❑ Elevated cholesterol
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy/seizure
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia
- ❑ Fibromyalgia
- ❑ Poor vision/hearing

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ Aneurysm
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**

During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**

Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Past surgical history (include dates): _____

_____

_____

Please list all current medications (prescription and non-prescription) _____

_____

_____

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Have you ever taken steroid medications for any medical conditions? **YES** **NO**
Do you smoke? **YES** **NO**
Are you latex sensitive? **YES** **NO**
Do you take blood thinners (e.g. Coumadin, plavix) **YES** **NO**
Do you have a pacemaker? **YES** **NO**
Do you take hormone replacement therapy? **YES** **NO**
Are you pregnant/possibly pregnant? **YES** **NO**
Do you take oral contraceptive therapy? **YES** **NO**
Does eating certain foods aggravate your symptoms? **YES** **NO**
Does coughing, sneezing, or taking a deep breath aggravate your symptoms? **YES** **NO**
Does bending, sitting, lifting or twisting aggravate your symptoms? **YES** **NO**

On the scales below, please circle the number which best represents the severity of your pain is.

Average for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

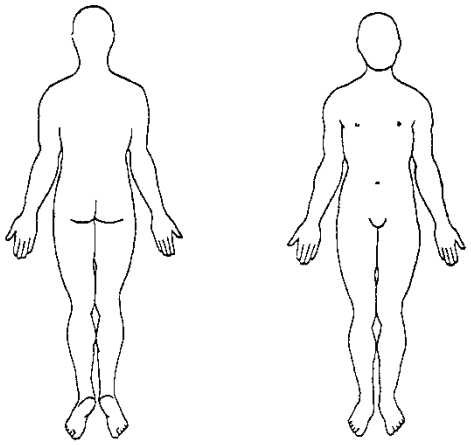
Best for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Worst for the last 48 hours:
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain Imaginable**

Body Chart:

Please mark the areas where you feel symptoms on the chart to the right

For the therapist
+/-Cough/Sneeze
+/-Saddle Anesth.
+/-Bwl/Bldd Chnge
+/-Numb/Ting.



What date (roughly did your present symptoms start _____
What caused your symptoms _____
_____

My symptoms are currently ❑ Getting Better ❑ Getting Worse ❑ Staying the Same

Please list any treatment received for this problem _____
_____

Please list any medication received for this problem _____
_____

Please list any activity/position that makes your symptoms worse _____
_____

Please list any activity/position that makes your symptoms better _____
_____

How are you currently able to sleep at night due to your symptoms:

❑ No Problem Sleeping ❑ Difficulty Falling Asleep
❑ Awakened by Pain ❑ Sleep Only with Medication

When you wake up do you have severe stiffness lasting greater than 1 hour: ❑ Yes ❑ No