RIVER CITY PHYSICAL THERAPY

HISTORY OF PRESENT CONDITION

Name:_____ Today's date:_____/_____/_____

Date of Birth:_____/_____/_____ Physician: _____

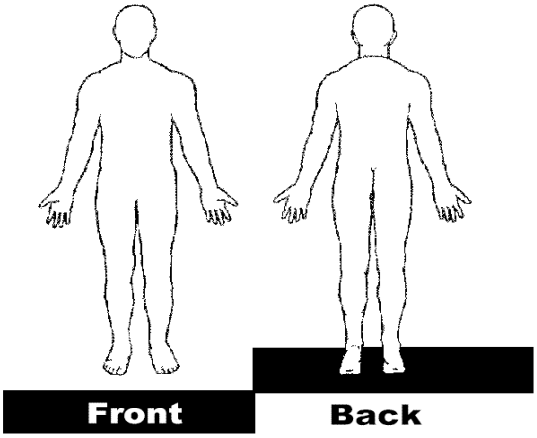
Who can we thank for referring you to us?_____

Has your health status changed since your previous injury/condition? Yes ____ no ____

What are your symptoms?
(if applicable) □ **R** □ **L**

_____
_____
_____

Shade areas of pain or abnormal sensation:



When did your symptoms begin?
Please indicate a specific date if possible:

_____
□ gradual onset
□ sudden onset

Describe how your symptoms began.

_____
_____

If you have had surgery for this condition,
Surgery date: _______________
Procedure: _____

Have you had similar symptoms in the past?
□ no
□ yes, once
□ yes, more than once

Nature of your symptoms (check all that apply)
□ sharp □ dull □ throbbing □ aching
□ numbness □ tingling □ shooting
□ periodic □ occasional □ constant

Severity of symptoms
Place a mark on the line to indicate your pain levels

At Rest:
_____
0 10
no pain worst pain

With Activity:
_____
0 10
no pain worst pain

What relieves your symptoms?

_____

What worsens your symptoms?

_____

Since the onset of your symptoms, have you had: (check all that apply)
□ fever/chills □ numbness □ dizziness
□ fainting □ weakness □ night pain
□ difficulty with bowel/bladder function
□ unexplained weight change
□ malaise (vague feeling of discomfort)
□ problems with vision / hearing
□ none of the above

Have you had any of the following tests for this condition:
□ x-ray □ other:
□ MRI
□ CT scan
Results: _____