



Physical Therapy & Functional History

Name: _____ Age: _____ Physician: _____

What are we seeing you for today? _____

Specific date of injury/onset of symptoms: (mm/dd/yy) _____

How did it occur? _____

List any previous treatments for this episode: _____

Notes:

Do you have: **Female** (Please check)

Male (Please check)

- Urinary or fecal incontinence
- Painful intercourse
- Prolapse
- Pain inserting tampons
- Pain with sitting
- Difficulty emptying bladder
- Constipation
- Urinary urgency/frequency

- Urinary or fecal incontinence
- Scrotal pain/Urinary
- Numbness/tingling of genitalia
- Tailbone pain
- Stop/start flow of urine
- Constipation
- Urinary urgency/frequency

Any recent health changes (i.e. significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc?)

Any allergies to tape/medications/latex? (List) _____

Have you had any of the following tests for this specific incident?

- CT Scan MRI X-Ray EMG Bone Scan Other

1. Have you had physical therapy for this problem before? Yes No When? _____

2. Have you had any falls in the past year? Yes No When? _____

3. Have you been hospitalized in the last year? Yes No When? _____

4. Are you currently being treated by another healthcare provider? Yes No Who? _____

5. What was your level of activity prior to your injury? (Check one) High Moderate Low

6. What was your level of fitness prior? (List activities) _____

7. What is your current level of fitness? (List activities) _____

8. Are you currently working? Full time light duty off homemaker N/A

9. What is your occupation? _____

10. What does it require? (Please check)

- | | | | | |
|-----------------------------------|---|-----------------------------------|-----------------------------------|--|
| <input type="checkbox"/> lifting | <input type="checkbox"/> pushing/pulling | <input type="checkbox"/> writing | <input type="checkbox"/> walking | <input type="checkbox"/> computer/typing |
| <input type="checkbox"/> twisting | <input type="checkbox"/> kneeling/crouching | <input type="checkbox"/> standing | <input type="checkbox"/> carrying | <input type="checkbox"/> sitting |
| <input type="checkbox"/> climbing | <input type="checkbox"/> repetitive movements | <input type="checkbox"/> reaching | <input type="checkbox"/> other | |

Physical Therapy & Functional History cont.

11. When is your next doctor appointment? _____ With Whom? _____

12. List goals you would like to achieve with coming to therapy

13. My pain is: aching burning stabbing pins and needles
 dull sharp other: _____

14. Use the following drawing and symbols shown to indicate the location and type of symptoms you are experiencing at the present time:

Sharp Pain

/////

Achiness

XXXXX

Burning

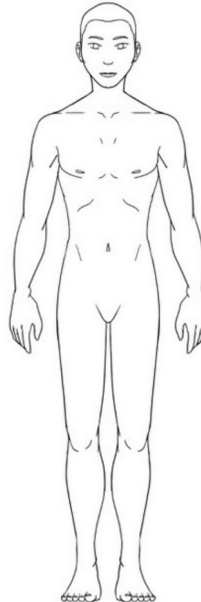
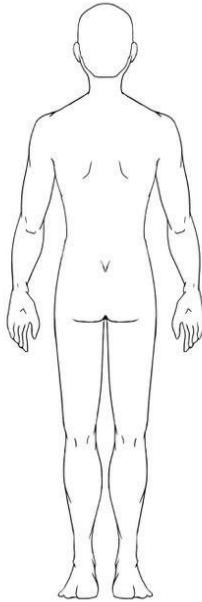
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Pins & Needles

0

Numbness

+++++



15. Is your pain worse in the (Please check) Morning Afternoon Evening

16. Is your pain (Please check) Constant Come and go

17. What makes your pain worse? _____

18. What eases your pain? _____

PRINTED Patient Name _____ Patient Signature _____ Date _____

 Therapist Signature _____ Date _____