**ROCKLIN PHYSICAL THERAPY**
**PATIENT SELF-HISTORY**

Name: _____ Date: _____

**1. MEDICAL HISTORY: Do you now have, or have you ever had any of the following? (check all that apply)**

**General Medical Conditions**

__ Diabetes (type I or II)
__ Arthritis (rheumatoid/osteoarthritis)
__ Allergies
__ Neurological Disease (MS, Parkinson's, seizures, etc)
__ Headaches
__ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
__ Visual Impairment (cataracts, glaucoma, macular degeneration)
__ Hearing Impairment (hard of hearing)
__ Prior Surgery(s) please list: _____
__ Cancer
__ Spine Pain (neck, low back, degenerative disk disease, spinal stenosis)
__ Hepatitis/AIDS
__ Osteoporosis/Osteopenia/Brittle Bones
__ Anxiety or Panic Disorders
__ Kidney, Bladder, Prostate, Urination Problems
__ Incontinence of Bladder or Bowels
__ Sleep Dysfunction
__ Prosthesis/Implants, Metal Implants

**Heart Disease**

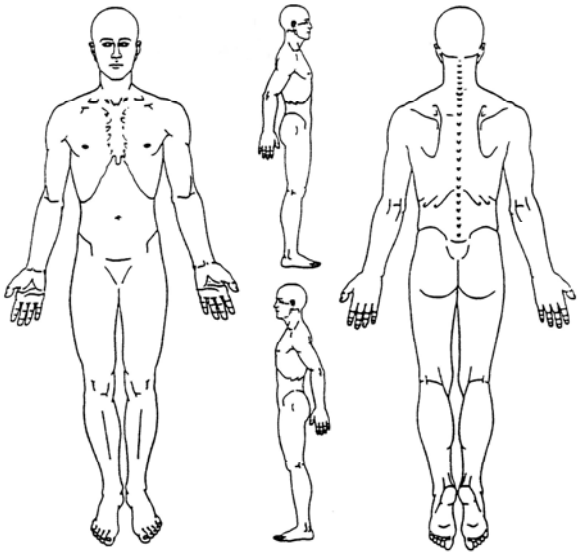
__ Congestive Heart Failure (CHF)
__ High Blood Pressure (hypertension)
__ Heart Attack (Myocardial Infarction/MI)
__ Atherosclerotic Disease/Coronary Artery Disease
__ Taking Blood Pressure Medication
__ Valvular Disease
__ Arrhythmia/Pacemaker
__ Angina
__ Heart Surgery

**Lung Disease**

__ Chronic Obstructive Pulmonary Disease (COPD)
__ Emphysema
__ Chronic Bronchitis
__ Asthma
__ Shortness of Breath
__ Recent Pneumonia

**Vascular Disease**

__ Peripheral Artery Disease (PAD)
__ Stroke/TIA
__ Taking Blood Thinner Medication



**2. PLEASE MARK ON THE FIGURE TO THE RIGHT WHERE YOU FEEL PAIN.**

**3. PLEASE ANSWER THE FOLLOWING:**

a. How long have you had the present problem/pain? _____
b. How long have you been unable to perform your normal activities due to this condition? _____
_____
c. Did your pain begin: (circle one) with injury gradually suddenly (without injury)
d. List your normal and/or work activities that you are unable to do or that increase your pain: (i.e., sitting, standing, walking, bending, lifting, etc.) _____
_____
e. Does a change in position relieve or reduce your pain? Please describe: _____
_____
f. Is your pain constant (never goes away) or intermittent (on and off)? _____
g. On a scale from 0-10 (0=best, 10=worst), what is your pain at **best**: _____ **worst**: _____ **average**: _____