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)

Heart Disease

__ Congestive Heart Failure (CHF)
__ High Blood Pressure/Hypertension
__ Heart Attack (Myocardial Infarction) (MI)
__ Atherosclerotic Disease (CAD)
__ Angioplasty
__ Taking Blood Pressure Meds
__ Valvular Disease
__ Stents
__ Arrhythmia/Pacemaker
__ Coronary Artery Bypass Graft (CABG)
__ Angina

Lung Disease

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

Vascular Disease

__ Peripheral Artery Disease
__ Acquired Respiratory Distress Syndrome (ARDS)
__ Taking anti-coagulants
__ Stroke/TIA

General Medical Conditions

__ Diabetes
__ Arthritis (rheumatoid/osteoarthritis)
__ Allergies
__ Neurological Disease (i.e. MS or Parkinson's)
__ Headaches
__ Gastrointestinal Disease (ulcer, hernia, reflux bowel, liver, gall bladder)
__ Visual impairment (cataracts, glaucoma, macular degeneration)
__ Back Pain (neck pain, low back pain, degenerative disk disease, spinal stenosis)
__ Hepatitis/AIDS
__ Osteoporosis, Brittle Bones
__ Anxiety or Panic Disorders
__ Kidney, Bladder, Prostate, Urination Problems
__ Incontinence of Bladder or Bowels
__ Hearing Impairment (very hard of hearing)
__ Sleep Dysfunction
__ Prothesis/Implants, Metal Implants
__ Cancer
__ Prior surgery(s) (please list) _____

2. PLEASE ANSWER THE FOLLOWING:

a. How long have you had the present problem/pain? _____
b. Did your pain begin: with injury gradually suddenly (without injury)
c. How long have you been off work or unable to perform your normal activities? _____
d. List your normal and/or work activities that you are unable to do or that increase your pain:_____
e. What activities or positions seem to lessen your pain? _____
f. Is your pain constant (never goes away) or on and off? _____

Name: _____

g. Have you been hospitalized or had related surgery for this problem? If so, what type?_____

h. Have any treatments made your pain better? Yes/No What type?_____

_____

i. Have any treatments made your pain worse? Yes/No What type?_____

j. How is your pain in the morning? Better Worse

k. How is your pain in the day? Better Worse

l. How is your pain at night or by the end of the day? Better Worse

m. What do you hope to achieve in therapy?_____

_____

3. MARK ON THE FIGURES BELOW WHERE YOU FEEL THE DESCRIBED SENSATIONS.

Please use the appropriate symbols:

Numbness

_____
_____
_____
_____

Stabbing

Pins & Needles

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Dull Ache

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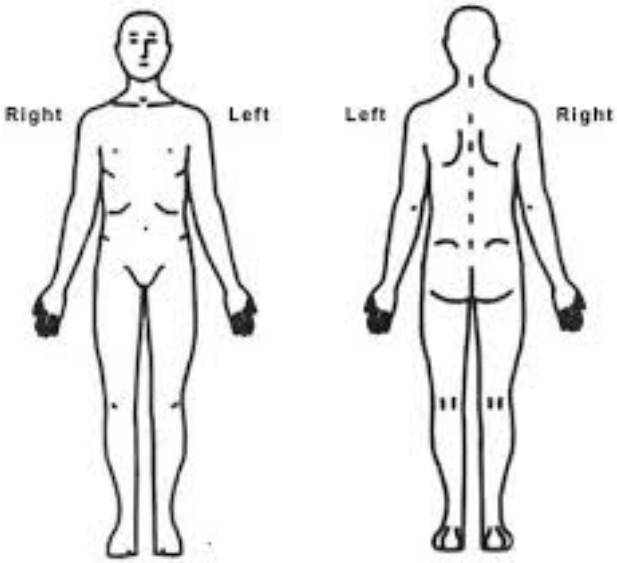
Burning

XXXXXXXXXX
XXXXXXXXXX
XXXXXXXXXX
XXXXXXXXXX



4. IF "0" REPRESENTS NO PAIN AND "10" REPRESENTS UNBEARABLE PAIN, PLEASE RATE YOUR PAIN BY CIRCLING THE APPOPRIATE NUMBER WHEN YOUR PAIN IS:

At its worst:	At its best:	Most of the time:
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Signature of patient (or caregiver): _____