RECOVERY PHYSICAL THERAPY, P.C.

New Patient History Form

Patient Name: _____ Date: ___/___/___ Diagnosis: _____

Referring MD: _____ Date of first MD visit for this injury: ___/___/___ Next MD appointment? ___/___/___
Gender: M F Birth Date: ___/___/___ Hand dominance: R L Occupation: _____
Height:_____ Weight:_____
Have you had any diagnostic tests performed? YES NO If so, indicate which tests & approximate dates:
X-ray:_____ MRI: _____ CT scan: _____ Bone Density: _____ Myelogram: _____
EMG: _____ NCV: _____ Other: _____

Have you missed any work due to this injury? YES NO
If so, last date worked was? _____ Date returned to work? _____ Worked part-time for a period of: _____

Have you had surgery for this injury? YES NO If so, how many surgeries? 1 2 3 4
Procedure(s) performed: _____
Most recent procedure: _____ Surgeon: _____ Date of last surgery: _____

Are you currently taking any prescription or non-prescription medications (for this condition or anything else)? YES NO
Please list in the appropriate categories:
Anti-inflammatories:_____ High Blood Pressure Meds: _____
Muscle Relaxers: _____ Bone Density Drugs: _____
Pain Medication: _____ Beta Blockers: _____
Antibiotics: _____ Other: _____

Have you sought care from any of the following medical providers for this injury/episode?

	YES	NO		YES	NO		YES	NO
Emergency Room Care	____	____	General Practitioner	____	____	Acupuncturist	____	____
Orthopaedist	____	____	Physical Therapist	____	____	Massage Therapist	____	____
Neurologist	____	____	Chiropractor	____	____	Other _____		
Podiatrist	____	____	Occupational Therapist	____	____			

When did you first notice symptoms of your problem? _____
Did your symptoms arise gradually? YES NO or Was there sudden onset? YES NO
Was there any trauma/accident that may have caused your complaints/problem? YES NO
Please elaborate: _____
_____

What are your present symptoms? _____
_____

How do your present symptoms compare to your original complaints? _____
_____

Rate your pain on a scale from **0** (no pain) to **10** (excruciating pain that is disabling and requires emergency care)
At the best moment in the last 48 hrs: _____ During the night: _____ At the worst moment in the last 48 hrs: _____

Is your pain **constant** or **intermittent** (circle one)? Does your pain wake you up at night? YES NO
Does your pain fluctuate based on your positions or activities? YES NO
Does your pain follow a pattern whereby it is worse in the **AM** or **PM** (circle one if yes)? YES NO
Does your pain radiate from one area to other areas? YES NO (explain below)
What activities of daily living are painful or difficult for you because of your problem? _____
_____

What can you do to alleviate pain? _____
Do you normally participate in any fitness activities or recreational sports? YES NO
List: _____

How have you modified your activities? _____

Did your referring MD give you any instructions (i.e.: for exercise, weight-bearing, weaning from crutches, use of a brace)?
YES NO Please elaborate: _____

_____

Orthopaedic History:

Please indicate **any musculoskeletal or neurological problems/injuries/surgeries you have experienced in the past**. Include even those that occurred long ago or seem completely unrelated.

CONDITION or INJURY / SURGERY	APPROX. DATES	DO YOU EXPERIENCE RESIDUAL SYMPTOMS? YES	NO
_____	_____	____	____
_____	_____	____	____
_____	_____	____	____
_____	_____	____	____

General Medical History: Do you now have or have you ever had ANY of the following:

	YES	NO	Use this space to explain
Allergies	____	____	_____
Anemia	____	____	_____
Arthritis: Osteoarthritis	____	____	_____
Rheumatoid arthritis	____	____	_____
Asthma	____	____	_____
Blood Clot/Embolus	____	____	_____
Blood Clotting Difficulty	____	____	_____
Bowel or Bladder problems	____	____	_____
Cancer	____	____	_____
Chemotherapy or Radiation	____	____	_____
Chest Pain	____	____	_____
Chronic Fatigue Syndrome	____	____	_____
Coronary Heart Disease or Angina	____	____	_____
Coronary Bypass Sx/Angioplasty	____	____	_____
Diabetes	____	____	_____
Dizziness or Fainting	____	____	_____
Emphysema/Pulmonary Problems	____	____	_____
Emotional/psychological problems	____	____	_____
Epilepsy/seizures	____	____	_____
Fibromyalgia	____	____	_____
Gout	____	____	_____
Headaches (severe or frequent)	____	____	_____
Hearing Difficulties	____	____	_____
Heart Attack	____	____	_____
Hernia	____	____	_____
High Blood Pressure	____	____	_____
HIV/AIDS	____	____	_____
Infectious Diseases	____	____	_____
Joint Replacement: (circle)	Hip	Knee	Shoulder Other _____
Lupus	____	____	_____
Lyme Disease	____	____	_____
Metal Implants or Pins	____	____	_____
Muscle Weakness	____	____	_____
Neurological Problems	____	____	_____
Numbness or Tingling	____	____	_____
Osteoporosis	____	____	_____
A Pacemaker	____	____	_____
RSD	____	____	_____
Sarcoidosis	____	____	_____
Shingles	____	____	_____
Shortness of Breath	____	____	_____
Sleeping Problems	____	____	_____
Stroke or TIA	____	____	_____
Thyroid trouble or goiter	____	____	_____
Vascular Problems	____	____	_____
Vision Difficulties	____	____	_____

Weight/energy loss ____ ____ _____

Other: _____

Are you pregnant? YES NO **Do you smoke?** YES NO

What are your goals while in this program? _____

Patient/Guardian Signature: _____ Print Name: _____Date:___/___/___