



Willow Physical Therapy, LTD
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PATIENT'S HISTORY OF PRESENT INJURY

Name: _____ Today's Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Marital Status _____ # Children _____ Ages _____

Occupation: _____ R-handed _____ L-handed _____ Ht. _____ Wt. _____

Have you ever been a patient here before? Yes _____ No _____; If yes, for the _____ same or _____ different problem?

Please indicate for which body region you are seeking treatment:

Neck Mid Back Low Back Shoulder Elbow Hand/wrist Hip Knee Ankle/foot Other

When did your symptoms start? Date _____ Can you identify a cause for your symptoms? Yes _____ No _____

If yes, specify: _____

Have you ever had similar symptoms in the past? Yes _____ No _____ If yes, when? _____

Have you recently had the following tests? Yes _____ No _____ If yes, check all that apply:

x-rays Bone Scan Myelogram EKG
 CT Scan EMG Stress Test Echocardiogram
 MRI Blood Tests Pulmonary Function Test Other (Please list) _____

Pain rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 _____ 1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ 7 _____ 8 _____ 9 _____ 10 _____
 Pain free Unconscious Pain

Describe the character of your pain? (What does it feel like...sharp, dull, achy, etc.?)

Is the pain there all the time (constant)? Yes _____ No _____

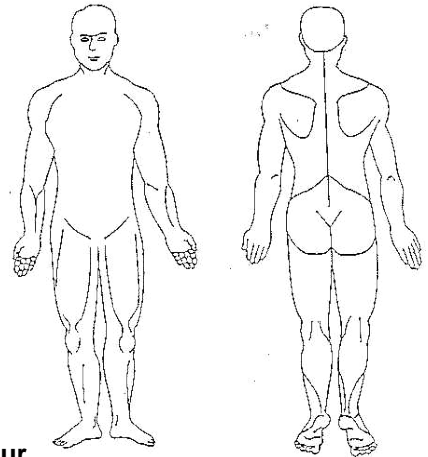
Does the pain move or radiate anywhere? Yes _____ No _____

If yes, describe location of radiation or numbness

Do you have numbness, tingling, or weakness? Yes _____ No _____

If yes, please describe: _____

(Please use the body diagram and Shade Areas of Pain)



Have you had any changes in your bowel, bladder or sexual function as a result of your symptoms? Yes _____ No _____ Describe _____

What activities/positions make your pain worse? _____

What activities/positions make your pain better? _____

Patient's History of Current Injury/Illness

Patient's Name: _____ Date: _____

Have you previously seen any other health care provider for this problem? ___ Yes ___ No

___ Physician ___ Osteopath ___ Podiatrist ___ Other (Please list below)
 ___ Physical Therapist ___ Chiropractor ___ Dentist _____

Are you currently seeing any other health care provider for this condition? ___ Yes ___ No; If Yes, please list:

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency in the past 30 days related to this condition? Yes ___ No ___ If yes, please describe: _____

Please circle those treatments listed below that have been tried in the past:

___ Physical Therapy ___ Chiropractic ___ Acupuncture ___ Braces ___ Collars ___ Tens Unit ___ Injections
 ___ Medications ___ None ___ Other (please describe): _____

RATING SCALE: For each activity listed below, please rate your ability using the ability scale (or mark not-applicable) and pain level (if any) using the pain scale (0-10) on the previous page:

1- Able to do without difficulty	2- Able to do with little difficulty	3- Able to do with moderate difficulty	4- Able to do with much difficulty	5- Unable to do
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Activity/Function/Skill	Ability	Pain Level	Prior Level of Function (Before Illness/Injury)	N/A
Rolling over in bed				
Transfer to/from bed				
Transfer to/from bath				
Bathing				
Dressing				
Grooming				
Balancing				
Sitting				
Kneeling				
Stooping/squatting/bending				
Standing				
Walking				
Stair climbing				
Lifting				
Reaching- level/overhead				
Carrying				
Transfer to/from car				
Driving				
Using telephone				
Meal preparation				
Household cleaning				
List Other Activities Affected by your symptoms (i.e. sports, hobbies, etc.)				

Patient's History of Current Injury/Illness

Patient's Name: _____

Date: _____

Medication Record:

Please list all current medications, with dosages (Include prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements).

If you already have a list (including dosage amounts) please check here and provide a copy of the list to your therapist at the time of your evaluation _____ (Patient initials)

Medication	Dosage	Reason for Taking

Use additional sheet if more space is needed

Where do you currently live (or intend to live) at the conclusion of your episode of therapy?

Private Home Private Apartment Rented Room Group Home Assisted Living Skilled Facility Other

Who do you live with (or intend to live with) at the conclusion of your episode of therapy?

Live Alone Spouse/Significant Other Child/Children Other Relative Personal Care Attendant Other

Job Description/Social Activities: (physical tasks, amount of sitting, lifting, computer work etc.): _____

What are your goals for your course of physical therapy? _____

At the present time, would you say your health is excellent, very good, fair, or poor? _____

Patient Signature

Date

Evaluating Physical Therapist Signature

Date