Bradley & Monson PHYSICAL THERAPY 212- 496-1187 Fax:212- 496-8196 **PATIENT HISTORY**

Patient First Name _____ **Last Name** _____ **Date** _____

Please describe briefly the condition and complaints you need physical therapy for: _____

_____

_____

Where do you have pain? _____

_____

Pain scale: please rate your pain level on a scale from 0 to 10 (circle below):

|----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|

0 1 2 3 4 5 6 7 8 9 10

NO PAIN MILD MODERATE SEVERE WORST

Functional limitations: I have difficulty with: _____

_____

Have you had any tests done? □ X-rays □ MRI □ CT scan □ other: _____

_____

_____

Have you had any other treatment for this condition? □ Yes, _____ □ No

Please list all the medications (including vitamins & supplements) you take: _____

_____

_____

Please list broken bones (fractures), injuries and motor-vehicle accidents you have had and when:

_____

_____

Please list any surgeries you have had and when: _____

_____

_____

Please check and / or list any other medical problems you have had or have now:

□ Heart disease □ Circulatory problems □ High blood pressure □ Diabetes

□ Seizure disorder □ Osteoporosis □ Asthma □ Cancer

□ Other _____

_____

Smoking History: □ I do NOT smoke □ I smoke □ I have been a smoker in the past for __ years.

Quit smoking date / year: _____

[For females only] I am □ pregnant or trying to get pregnant □ NOT pregnant.

My age: _____ My height: _____ My weight: _____ I am □ Right handed □ Left handed

My weekly exercise routine consists of: _____

_____

_____

What are your goals / expectations of treatment?: _____

_____

_____