OASIS PHYSICAL THERAPY: PATIENT MEDICAL INFORMATION

Name____Date___________

Referring Doctor________________________Family Doctor______________

Are you under the care of another practitioner(chiropractor, massage therapist, etc)? Yes____No____

Name of this practitioner_______________________________________

Please check any of the following that you have had:

High Blood Pressure_____

Stroke______

Diabetes______

Cancer______

Heart Attack______

HighCholesterol_____

Asthma_____

Surgeries_____

Allergies______

Incontinence of bladder or bowel________

Liver/Kidney Disease ______

Please explain any conditions you checked above_______________________

____

What medications are you taking?_____________________________________

____

Please circle if you have had---X-Ray, MRI, EMG, Ultrasound, arthrogram, other________

Where and when were they done?

____

What were the results?

____

DESCRIBE YOUR SYMPTOMS:____

____

On a pain intensity scale of 0-10, (0 is painfree, 10 is extreme pain), what is your pain level right now?.______, Lowest level in past 48 hours? ________Highest level in past 48 hours?_______

What do you do for exercise now?

____

What exercise did you do before this problem?

____

Describe generally what your activity level is now and how it is different from before your injury.

____

List your stress management activities______________________________

____

What do you hope to achieve from Physical Therapy?

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