WELCH PHYSICAL THERAPY

Welch Physical Therapy
WelchPT.com

Patient Name: _____ Sex: ☐ M ☐ F Occupation: _____ DOB: _____

MEDICAL/SURGICAL HISTORY							
	YES	NO	Comments		YES	NO	Comments
Heart Disease				Arthritis			
Heart Attack				Osteoporosis			
High Blood Pressure				Joint Replacement			
Low Blood Pressure				Shortness of Breath			
Diabetes Mellitus				Kidney/Urinary			
Cancer				Epilepsy/Seizures			
Respir. (asthma/COPD)				Stomach/Gastrointestinal			
Bowel/Bladder changes				Stroke			
Tuberculosis (TB)				Pacemaker			
Circulation/Vascular				Unusual Weight Gain/Loss			

Other:_____
List prior surgeries/injuries:_____ _____
_____
Current Medication: _____
Present injury: _____
Date of onset: _____ Previous physical therapy Y / N Explain: _____
Previous treatment (injection, Chiropractor, etc.)_____
Imaging (ie. Xray, MRI, CT, etc.) _____
Chief complaint/symptoms: _____

☐ Constant ☐ Rapid onset ☐ Improving
☐ Intermittent ☐ Slow progressive onset ☐ Worsening

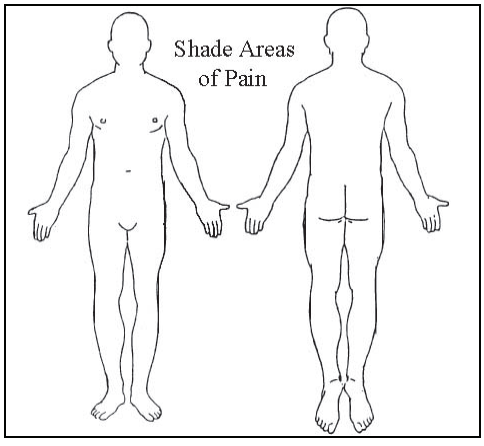
As result of ☐ _____ ☐ No apparent reason
Worse: bending / lifting / sitting / standing / turning head R or L / twisting / lying / stationary / on the move / am / pm
Other _____
Better: Lying on back, side, stomach / sitting / standing / stationary / on the move / am / pm
Other _____
Disturbed sleep: Y / N Awakened _____times/night with symptoms.
Cough/Sneeze = Pain Y / N
Occupation: _____ Off work Y / N Since when _____ Return Date_____
Recreation: _____ Limited Y / N Since when_____
Functional Activities Limited Y / N _____
Do you wear: ☐ Orthotics ☐ Brace ☐ Prosthesis ☐ Other_____

Typically, my pain level is:
0 1 2 3 4 5 6 7 8 9 10

At its worst, my pain level is:
0 1 2 3 4 5 6 7 8 9 10

At its best, my pain level is :
0 1 2 3 4 5 6 7 8 9 10

0 = No Pain 5 = Moderate Pain 10 = Severe Pain



SIGNATURE / Patient _____ Date_____

Therapist _____ Date_____