Jeff Nicholl Physical Therapy & Sports Rehabilitation Inc.

Patient History

Name: _____

Age: _____ Occupation: _____ Presently working? yes ☐ no ☐

Activities/ExerciseRoutine_____

Current Condition:

1. What major complaint, symptom or problem brings you here?

_____

2. What activities aggravate your condition?

_____

3. What relieves your symptoms?

_____

4. Progression of current condition (circle one): better worse same

5. Please rate your pain on a scale of 0-10: (circle one)

0 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

6. What tests/ and or treatment have you had performed for this problem?

_____

7. What medications are you taking for this problem? _____

Other medications: _____

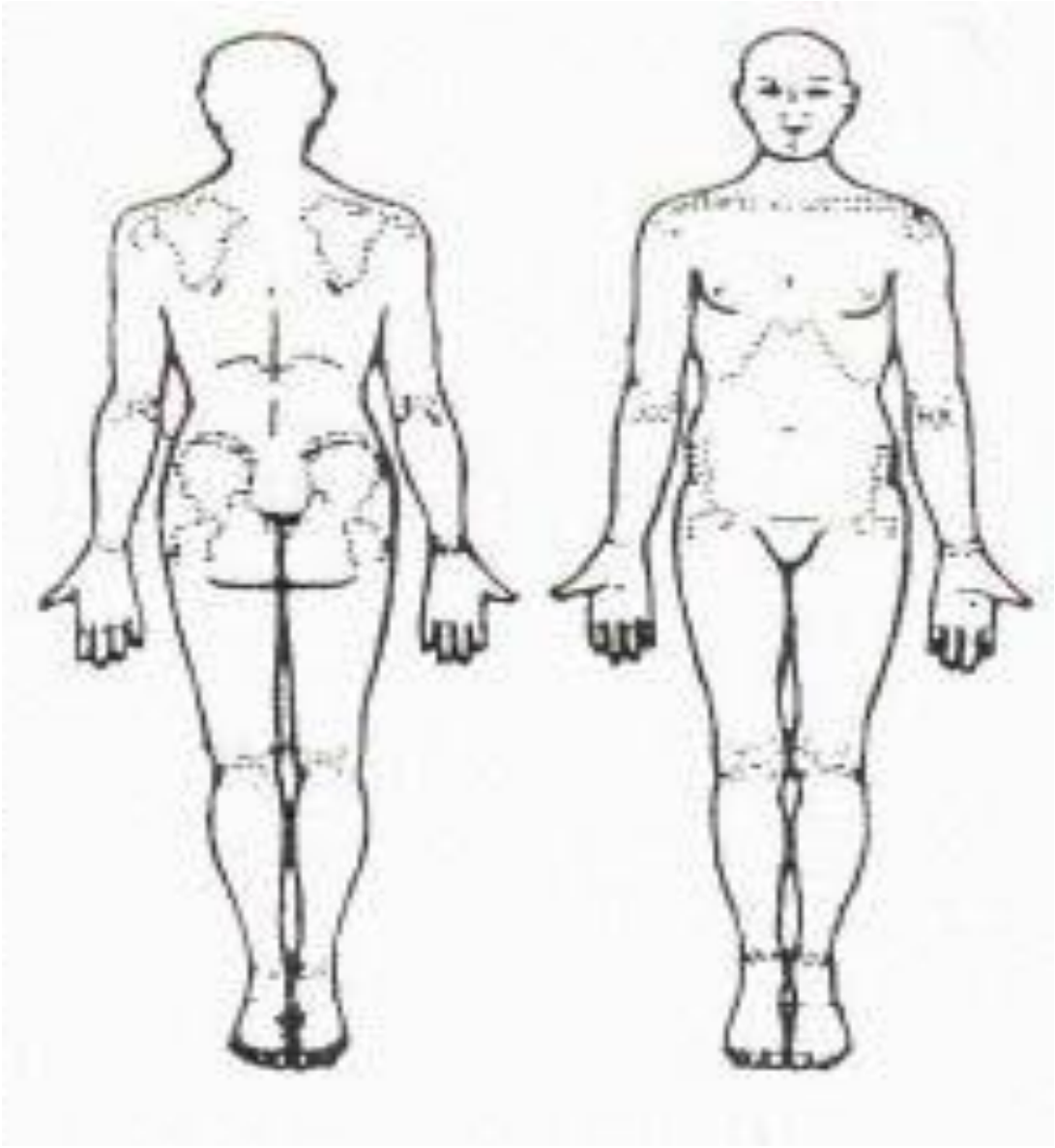
8. Past Medical History: Have you been diagnosed with or experienced any of the following:

Allergy _____
Balance Problems _____
Bowel/Bladder Problems _____
Cancer Type _____
Cardiac Condition_____
Chemical Dependency_____
Diabetes_____
Dizziness _____
Gastrointestinal_____
Headaches/Migraines_____
Hypertension (High blood pressure)
Numbness _____
Neurologic condition _____
Osteoarthritis _____
Osteoporosis _____
Psychological condition _____
Respiratory _____
Rheumatoid Arthritis _____
Seizures _____
Thyroid _____
Weakness _____
Pace Maker _____
Other _____

9. To what extent are your daily activities limited?
(circle one) mild moderate severe

10. What are your goals for coming to therapy?

_____
_____
_____



Please shade the areas of pain in the above picture

//////////	**Dull Shooting**
XXXX	**Sharp Tingling**
AAAA	**Aching Numbness**
OOOO	**Only with movement**

Comments:_____

_____

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.
- I acknowledge that I was provided a copy of the Notice of Privacy in compliance with HIPPA and understood the notice.

Patient's Signature (x) _____ **Date** _____