

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: _____

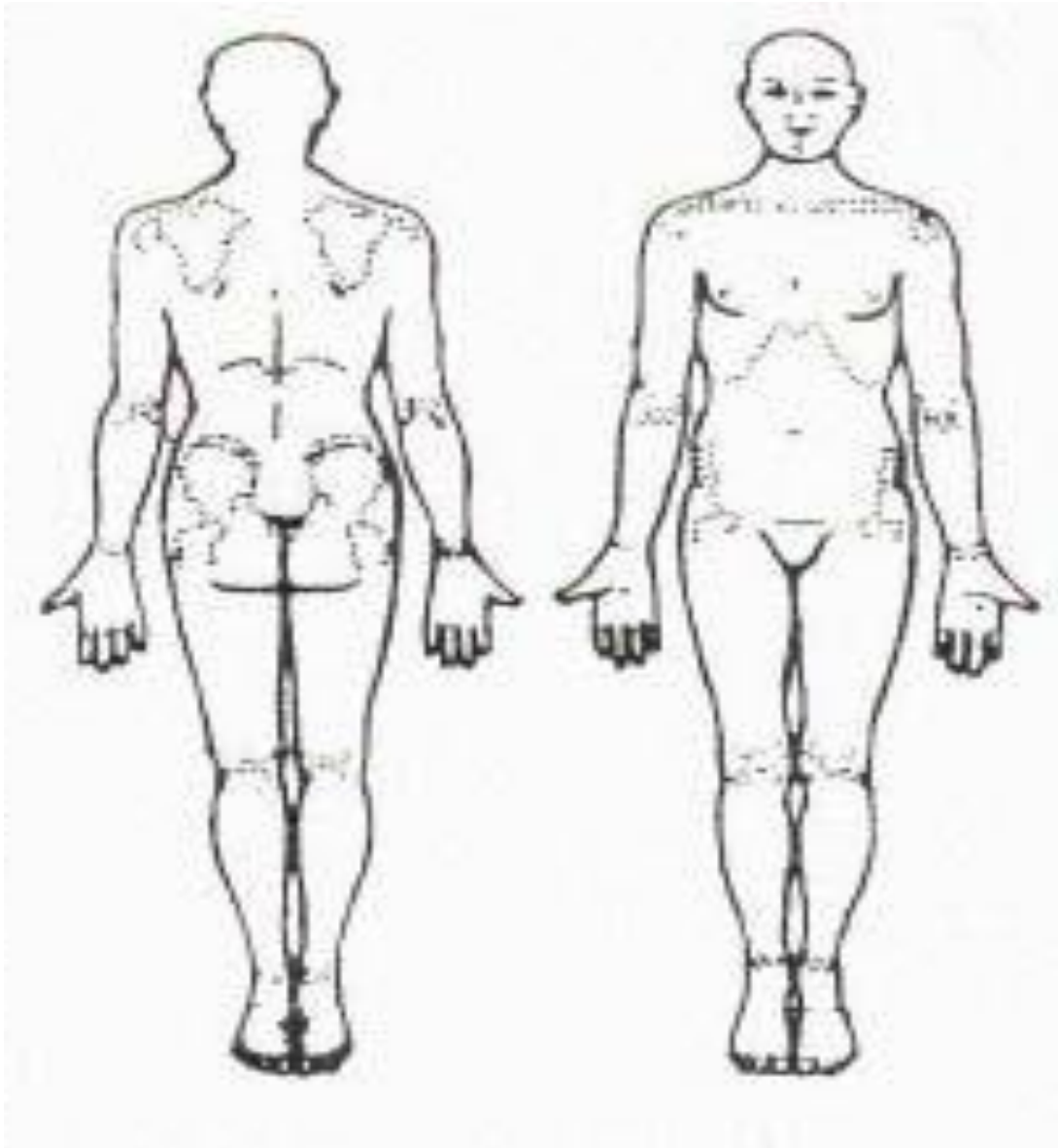
8. Past Medical History: Have you been diagnosed with or experienced any of the following:

Allergy _____	Numbness _____
Balance Problems _____	Neurologic condition _____
Bowel/Bladder Problems _____	Osteoarthritis _____
Cancer Type _____	Osteoporosis _____
Cardiac Condition _____	Psychological condition _____
Chemical Dependency _____	Respiratory _____
Diabetes _____	Rheumatoid Arthritis _____
Dizziness _____	Seizures _____
Gastrointestinal _____	Thyroid _____
Headaches/Migraines _____	Weakness _____
Hypertension (High blood pressure)	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

//////////
XXXX
AAAA
OOOO

Dull Shooting
Sharp Tingling
Aching Numbness
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** _____