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? (Sitting, standing, bending, walking, other?)
   ____

3. What relieves your symptoms? (Sitting, standing, bending, walking, other?)
   ____

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 current problem? ______________________________

8. Please list **ALL medications** you are currently taking: ____

   ____

   *Have you ever taken the medication **levofloxacin (levaquin—antibiotic)**? Yes ☐ No ☐
   *If yes, when did you start/stop taking **levofloxacin (levaquin—antibiotic)**? _______________

9. **Past Medical History: Please check ALL that apply**

Previous Physical Therapy this year? _____ **How many visits?** ______

History of cancer ______
Alzheimer's ______
Blood Thinners______
Cardiovascular Disease ______
Cauda Equina Syndrome ________
Cerebral Vascular Accident_______
Current Infection_______
Diabetes Mellitus Type 1______
Diabetes Mellitus Type 2 ______
Fracture or suspected fracture______
Traumatic Brain Injury ________
Hypertension (high blood pressure) _____

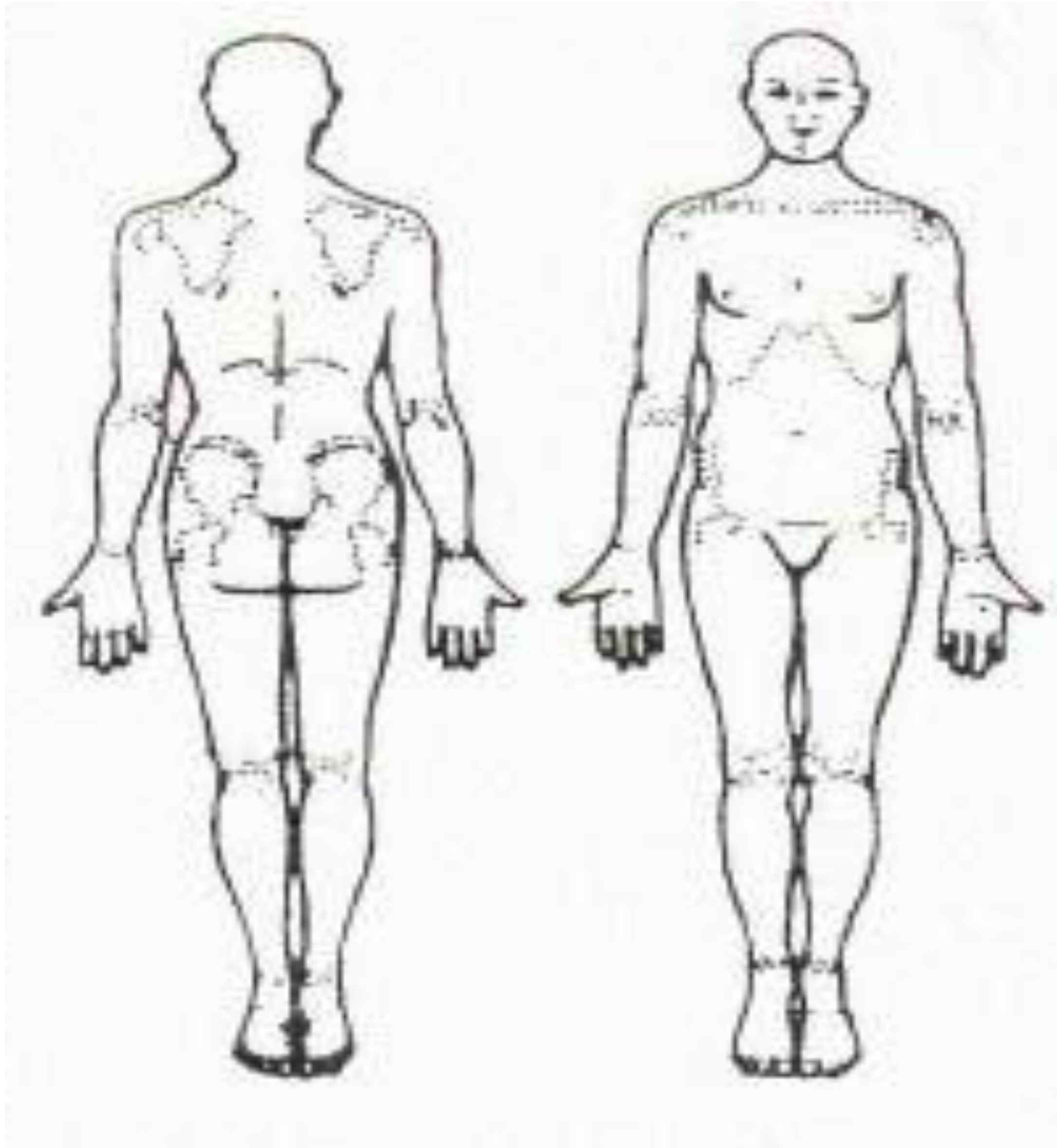
Fibromyalgia________
Huntington's _______
Immunosuppression _______
Lupus ________
Muscular Dystrophy ______
Obesity _______
Osteoarthritis ________
Rheumatoid Arthritis ________
Parkinson's _________
Spinal Stimulator_________
Pace Maker _________
Other ___________________________________

Please list any previous surgeries ____

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

11. 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** ________________