

Sims Physical Therapy

2530 Professional Parkway, Santa Maria, CA 93455
(805)928-4465 (805)928-7935

Patient History Form

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Patient Name: _____
Family Doctor: _____

DOB: ___/___/___ Date: ___/___/___
Reason for Physical Therapy? _____

Are you currently working? Yes No

If yes, what date were they taken? ___/___/___

Work Activities: _____

Light Heavy Very Heavy

Light Heavy Very Heavy

Light Heavy Very Heavy

Light Heavy Very Heavy

Were X-rays Taken? Yes No

If yes, what date were they taken? ___/___/___

How did onset of pain occur? _____

Do you have any previous history of same injury or pain episodes? Yes No

If yes briefly explain: _____
_____ Date ___/___/___

Have you had previous physical therapy for your condition? Yes No

Dates of service? ___/___/___ to ___/___/___

Are you presently taken medication? Yes No
MEDICATION

If yes, please list medication and for what condition
CONDITION

Please continue on the back if not enough space

Describe your present symptoms: _____

Do you have or ever had the following? Please check yes or no.

Diabetes Yes No

Cancer Yes No

High blood pressure Yes No

Sensory Problems Yes No

Heart Disease Yes No

Nervous Disorders Yes No

Heart Attack Yes No

Allergies Yes No

Pacemaker Yes No

Previous Surgery Yes No

Headaches Yes No

Seizures Yes No

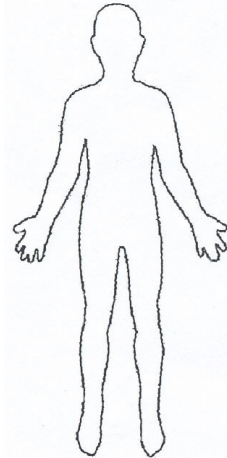
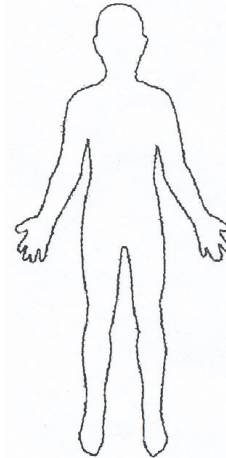
Kidney Problems Yes No

Hernia Yes No

Currently Pregnant Yes No

Metal Implants Yes No

Hepatitis C Yes No



front

back

Mark on the body chart the following sensations: Pain-P Numbness-N Tingling-T

Do you have pain with: Standing Sitting Coughing Lying on stomach Lying on back

Pain is: Constant Intermittent Sharp Dull

What makes pain worse? Briefly explain: _____

Is the pain better or worse as the day progresses? Better Worse

Does the pain awaken you at night? Yes No Is pain present upon awakening? Yes No

Patient's Signature: _____