Sims Physical Therapy
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915 E. Stowell Rd. STE D Santa Maria, CA 93454 **Phn.** 805.314.2567

Patient History Form

Patient Name:	Family Doctor:	DOB: ___/____/____
Chief Complaint:		
How did the injury Occur?		
Date of Onset:	Surgery Date:	Reason for Surgery:

Average pain intensity: last 24 hours : no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

past week: no pain ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ worst pain

Do you experience? ☐ Radiating pain ☐ Numbness ☐ Tingling ☐ Sleep Disturbances

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

How often have your symptoms interfered with your usual daily activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

What activities/treatments improve your symptoms?

What activities/treatments worsen your symptoms?

Is this injury a result of an accident? ☐ n/a ☐ auto ☐ slip and fall ☐ work related ☐ other

Occupation: Are you currently off work due to your injury? ■ Yes ☐ No

Work activities most include (check all that apply)

☐ Sitting ☐ Lifting ☐ Use of computer ☐ Bending
☐ Standing ☐ Walking ☐ Driving ☐ Other_____

List any diagnostic test or injections for this condition (MRI, X-ray, CT scan etc.):
Where was it done?

Are you currently receiving any other care for this condition? ☐ Yes ☐ No
If yes, what treatment?

Have you received therapy in the past for this condition? ☐ Yes ☐ No
If so, was it ☐ Successful ☐ Unsuccessful

Medication Name	Delivery Method	Strength	Frequency
	☐ Oral ☐ Injection		
	☐ Oral ☐ Injection		
	☐ Oral ☐ Injection		
	☐ Oral ☐ Injection		
	☐ Oral ☐ Injection		

Are you currently experiencing any flu type symptoms? (i.e. fever, coughing) ☐ Yes ☐ No
If yes what symptoms?

Do you have any open wounds, cuts, or lesions? ☐ Yes ☐ No

Do you have or have you had any of the following (check all that apply)

☐ Asthma	☐ Cancer	☐ COPD
☐ Currently pregnant	☐ Diabetes	☐ Epilepsy
☐ Heart Condition	☐ Hypertension	☐ Metal Implants
☐ Osteoarthritis	☐ Osteoporosis	☐ Pacemaker/Difibulator
☐ Hepatitis (☐ A ☐ B ☐ C)	☐ Previous surgery	☐ Rheumatoid arthritis
☐ Stroke History	☐ Hearing problems	☐ Problems urinating
☐ Recent infection	☐ joint/muscle swelling other	☐ Hernia
☐ HIV/AIDS	☐ Kidney Problems	☐ Other

My next appointment with my doctor is on _____/____/_____ ☐ No appointment scheduled
What goals do you have for therapy and what do you hope to accomplish?

Patient/Legal Representative Signature:	Date:
Therapist Signature:	Date: