Absolute
Physical Therapy

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PATIENT HISTORY FORM

Thank you for providing the following important information to help us help you. Please let us know if you have any questions

Patient's Name: _____ Date of Birth:_ _____ Height:_____ Weight:_____

Primary Complaint: _____

Pain levels: Best 0-10 _____ Worst 0-10_____

When did your symptoms begin: _____Was there surgery: YES / NO Surgery Date:_____

What caused them to start: _____

What makes your symptoms worse: _____

What makes your symptoms better: _____

What treatments have you received: _____

Smoker: YES / NO

FLU Vaccine YES/ NO

Pneumonia Vaccine YES/NO

Any falls this year with injury: YES / NO

How many Falls: _____

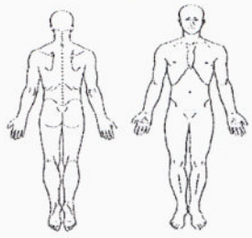
Cancer YES / NO Cancer Type_____

Diabetes YES / NO

Stroke YES / NO When: _____

Pacemaker /Defibrillator YES / NO

NT Numbness/Tingling
A Ache
B Burning
S Sharp
D Dull



Allergies: _____

Other related or recent medical history_____

Medications: _____