Powers Physical Therapy, LLC

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Lesley Powers, PT, DPT

Patient Medical History

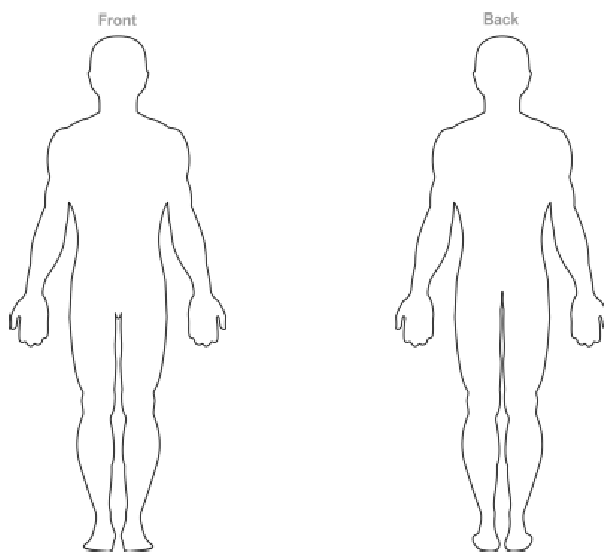
Name: ________________________________ Date of Birth: ___________ Today's Date: ___________

Please give a brief description of your CURRENT CONDITION ____________________________________
____
____
____
____
____

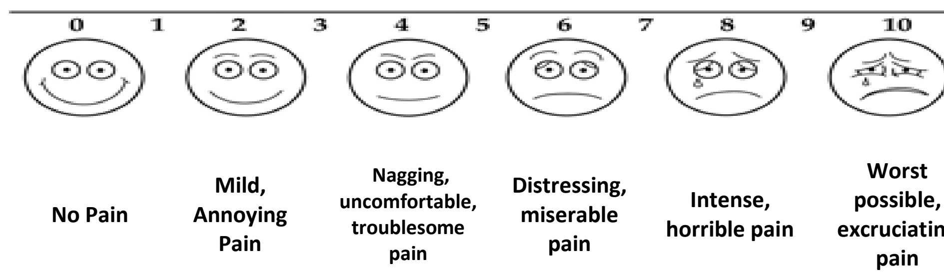
Please indicate areas of the body where you are experiencing pain or discomfort.

——— Solid for pain

------ Dotted for numbness/tingling



Mark current (C), lowest (L) and highest (H) pain experience on the scale below



0	2	4	6	8	10
No Pain	**Mild, Annoying Pain**	**Nagging, uncomfortable, troublesome pain**	**Distressing, miserable pain**	**Intense, horrible pain**	**Worst possible, excruciating pain**

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Name: ______________________________ Date of Birth: ___________ Today's Date: ___________

Please list all PAST SURGERIES and approximate dates (indicate the involved side)

Please list all past INJURIES and MAJOR or CURRENT ILLNESSES

Please list any ALLERGIES you have

Please list all current MEDICATIONS and SUPPLEMENTS (or attach a list)

Medication Name	Dosage	Frequency	Method of Administration (Oral, topical, etc.)	Notes

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Name________________________________ Date of Birth____________ Today's Date____________

PLEASE **MARK WITH A ' C '** FOR ANY CONDITION YOU **CURRENTLY HAVE**. PLEASE **MARK WITH A ' P '** FOR ANY **PAST CONDITIONS.**

__ High Blood Pressure

__Low blood Pressure

__High Cholesterol

__Chest pain

__Neurologic disease

__Anxiety

__Aneurysm

__Kidney Stones

__Migraines

__Headaches

__Fainting

__Dizziness

__COPD

__Shortness of Breath

__DVT (blood clots)

__Gall Stones

__Asthma

__Osteoporosis

__Thyroid Disease

__Diabetes

__Numbness

__Tingling

__Fatigue

__Acute Infection

__Ulcers

__Heartburn

__Hepatitis

__Anemia

__Autoimmune Disease

__Depression

__Fractures

__Pacemaker

__Cancer

__Seizures

__Heart Attack

__Loss of Bowel or Bladder Control

__Unexplained weight loss/gain

__Metal Implant

Have you had any falls in the past year? **Y/N.** If yes, how many? _________________________________

Do your symptoms wake you at night? ____

Are your symptoms constant or intermittent? ____

Do you have an unexplained fever or chills? ____

What makes your symptoms worse? ____

What makes your symptoms better? ____

Height __________ Weight ______________

FOR WOMEN:

Are you pregnant, think you may be pregnant, or are you planning on becoming pregnant in the near future? ___________________________________

Do you currently have any children? ___________

Do you have an IUD? ________________________

I verify the above information to be true (sign) _______________________________ Date: __________