COLUMBIA PHYSICAL THERAPY, P.C.

3 Springhurst Drive
Suite #1
East Greenbush/Rensselaer
New York 12061

Ocean State Job Lot
P.O. Box 187, Route 9
Valatie/Kinderhook
New York 12184

DOREEN FRANK P.T.
ROBERT FRANK P.T.
and ASSOCIATES

PATIENT HISTORY

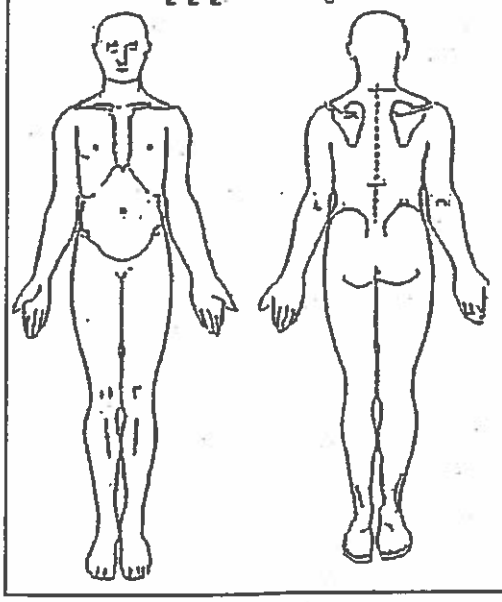
PATIENT: _____ DATE: _____

1. How did you know about us? (Check all that apply)
   - ☐ Doctor Recommended us
   - ☐ Internet Search / Our Website
   - ☐ Cindy Brocks
   - ☐ Family / Friend
   - ☐ Yellow Pages
   - ☐ Prior Patient
   - ☐ Direct Access
   - ☐ Doctor Script List
   - ☐ Other _____
2. When do you see your doctor again? _____
3. What is your primary problem? _____
4. Do you have any secondary problems? _____
5. How did your problems begin? _____
6. When did your problem begin? _____
7. Have you ever had anything similar before? ☐ Yes ☐ No
   Tell me about it: _____
8. What is your work/hobby? _____
9. Are you working? ☐ Yes ☐ No
   If no, is it because of your problem? ☐ Yes ☐ No
10. Just prior to the onset, were you completely free of symptoms?
    ☐ Yes ☐ No
11. What, if any, treatments have you had for this current problem?
12. Did they help? ☐ Yes ☐ No
13. What in particular makes your pain worse? _____
14. What, if anything, eases the pain? _____
15. 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**
16. Have you had x-rays, MRI or any diagnostic tests_____
    If so, when and what were the results? _____
17. Can you get comfortable at night? ☐ Yes ☐ No
18. How do you feel upon rising? ☐ Stiff ☐ Sore ☐ Fine
19. Once you start moving about does it ☐ Worsen ☐ Ease
20. What is it like at the end of the day? ☐ Worse ☐ Easier
21. Do you have any pins and needles, etc.? ☐ Yes ☐ No
    If yes, Please mark diagram to the right.
22. Are you taking any medications? ☐ Yes ☐ No
    LIST ALL THE MEDICATIONS YOU TAKE: _____
23. At this time do you consider you are getting ☐ Better ☐ Worse ☐ Stable
24. Surgical History: _____

*Patient to fill in
CHECK ALL THAT APPLY:

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Asthma
☐	☐	HIV / AIDS
☐	☐	Cancer
☐	☐	Tumor
☐	☐	Systemic Lupus
☐	☐	Hepatitis
☐	☐	Epilepsy
☐	☐	Diabetes
☐	☐	Rheumatoid Arthritis
☐	☐	Arthritis
☐	☐	Pregnancy
☐	☐	Other _____
☐	☐	Tobacco _____ packs/day
☐	☐	Drug or Alcohol Dependent

Comments: _____

SITES OF PAIN AND PARESTHESIA

KEY: ∴ = Numbness XXX XX = Severe Pain ↙↙↙ = Shooting Pain