Physical Therapy Clinic
Northern Illinois University
DeKalb, IL 60115-2879
Phone: (815) 752-2675
Fax: (815) 752-3299

Name ______________________________
Identification Number______________________________
Date of Birth ______________ Phone Number ______________

PHYSICAL THERAPY PAST MEDICAL HISTORY

Your chief complaint? ______________________________

____

How and when did this injury first occur? ______________________________

____

Briefly describe any previous injuries and the approximate date of injury:

Date: ______________ Injury: ______________________________

Date: ______________ Injury: ______________________________

Please list any medications you are currently taking: ______________________________

____

Have you undergone any diagnostic tests for this condition? (please check the appropriate responses)

X-ray ______________ MRI ______________ CAT Scan ______________

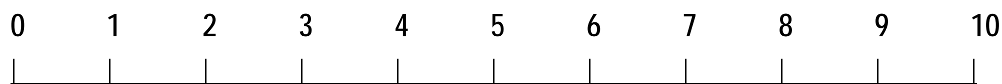
Other ______________________________

Do you have any tingling, numbness or loss of skin sensation? Yes _____ No ______

If yes, please describe ______________________________

Please rate the severity of the symptoms/pain you are currently experiencing:

0 1 2 3 4 5 6 7 8 9 10



No Pain **Worst Pain**

Please check the symptoms which describe your pain:

_____ dull ache	_____ sharp	_____ shooting
_____ stiffness	_____ constant	_____ on and off
_____ worse in a.m.	_____ worse in p.m.	_____ awakens you at night

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What increases your pain?

____ stair climbing ____ sitting ____ walking ____ athletics

____ standing ____ lying ____ static positions

Other ______________________________

What alleviates your pain? ______________________________

Circle all that apply related to your Past Medical History:

Cancer Diabetes Heart Issues Breathing Issues High Blood Pressure Heat/Cold Intolerance Surgeries

Do you have any other Past Medical History we should be aware of? (please specify) ______________

____

Are you pregnant? ______ Yes ______ No

Does this condition cause you to have headaches? ______ Yes ______ No

How often? ______________________________

Have you had physical therapy before? ______________________________

What recreational or work-related activities do you engage in? ______________

____

What are your goals for Physical Therapy? ______________________________

____

Are you currently seeing any of the following?

Medical Doctor Yes ___ No ___ Chiropractor Yes ___ No ___

Psychiatrist/Psychologist Yes ___ No ___ Attorney Yes ___ No ___

Physical Therapist Yes ___ No ___ Other ______________________

Signature ______________________________ Date ______________

Reviewed by (therapist signature)______________________________ Date ______________