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PATIENT HEALTH HISTORY

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Referring Physician \_\_\_\_\_ Have you seen any other physicians for this condition? \_\_\_\_\_

Do you have cancer? [ ] yes [ ] no Do you have a pacemaker/electronic stimulator/other electronic device? [ ] yes [ ] no

Are you pregnant? [ ] yes [ ] no Are you working? If yes, [ ] regular duty [ ] light duty Occupation \_\_\_\_\_

What type of injury is this? [ ] motor vehicle [ ] work-related [ ] chronic
[ ] Other \_\_\_\_\_

FOR PHYSICAL THERAPIST'S USE ONLY

What are your present symptoms? \_\_\_\_\_

When did they start? (approximate date) \_\_\_\_\_

How did they start? \_\_\_\_\_

Have you had any other physical therapy recently? [ ] Yes [ ] No

If Yes, Who & When \_\_\_\_\_

Was the onset [ ] Acute Trauma [ ] Repetitive/Overuse [ ] Gradual?

Have you had similar symptoms in the past? [ ] yes [ ] no

Are your symptoms getting [ ] worse or [ ] better?

As the day progresses, do your symptoms:

[ ] Increase [ ] Decrease [ ] Stay the same?

Does pain wake you up at night? [ ] yes [ ] no

Is it worse when you are: [ ] lying still [ ] changing positions?

Do you have pain or stiffness when getting out of bed in the morning?

[ ] yes [ ] no

What kind of pillow do you sleep on?

[ ] soft/flat [ ] medium [ ] full [ ] contour [ ] other \_\_\_\_\_

What kind of mattress do you sleep on?

[ ] soft [ ] medium [ ] firm [ ] futon [ ] other \_\_\_\_\_

What position do you sleep on at night?

[ ] stomach [ ] back [ ] side [ ] side, leaning toward stomach

[ ] side, leaning toward back [ ] other \_\_\_\_\_

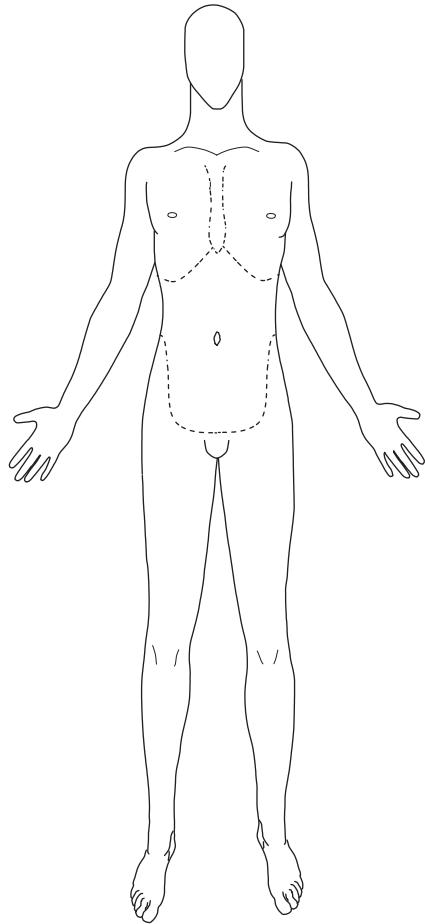




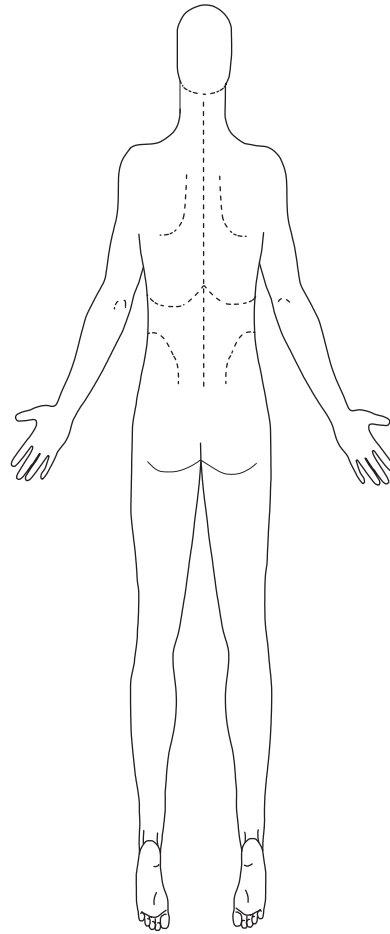


Please mark the diagrams below showing the location and severity of your pain using the following symbols:

**N** Numb, no feeling   **T** Tingly   **M** Mild Pain   **X** Moderate Pain   **S** Severe Pain   **!** Shooting Pain



**Right –FRONT-Left**



**Left-BACK-Right**



**Right**



**Left**