CHESAPEAKE PHYSICAL THERAPY

Patient Information/Health History

Patient Name____ Date ________________________________

Date of onset, injury, or surgery__________________ What was your initial treatment? ________________________

Have you had other treatment for this condition? Yes ______ No ______ If yes, please explain _____________________

Are you taking any medication now? Yes ________ No_________ If yes please list all medications:

If you need to, please continue your medications list on the back.

Medications / Dosages

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Please check below any diagnosis that is a part of your current or previous medical history:

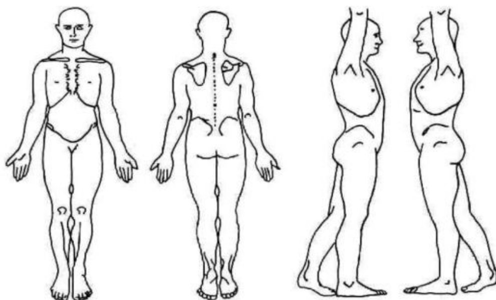
Diabetes	________	High Blood Pressure	________
Heart Disease	________	Stroke/CVA	________
Pacemaker	________	Migraine Headaches	________
Kidney Problems	________	Rectal Bleeding	________
Allergies (list below)	________	Bowel/Bladder Irregularity	________
Hernia (Ventral, Inguinal, etc.)	________	Seizures	________
Metal Implants	________	Dizziness	________
Cancer	________	Pregnant (currently)	________
Abdominal Pain	________	Menstrual Irregularity	________
Muscle Disease / Disorder	________	Nerve Disease / Disorder	________

Previous Surgeries (list year & type): ____

Any other medical conditions the Physical Therapist should be aware of: __________________________________

If you have checked any diagnosis above, please explain on back and give approximate dates.

Pain Chart & Questionnaire:



Please mark the body charts above in the areas where you experience pain related to today's therapy visit.

Briefly Describe your pain: (circle all that apply):

constant intermittent sharp dull achy burning

Pain Scale: Please circle level of pain

Current:	0 1 2 3 4 5 6 7 8 9 10 No pain moderate pain worst pain possible
At its best:	0 1 2 3 4 5 6 7 8 9 10 No pain moderate pain worst pain possible
At its worst:	0 1 2 3 4 5 6 7 8 9 10 No pain moderate pain worst pain possible

Any further description/explanation of pain: ________________________

I certify to the best of my knowledge, the above information is correct.

I understand I will be provided with a description of my individualized physical therapy treatment plan to be rendered. It will include the potential benefits and any associated risks of physical therapy. I understand that my attendance, in accordance with the prescribed treatment plan, is critical to maximizing the potential benefits of my physical therapy treatment plan. I have read and understand the information above, and agree to consent to physical therapy treatment to be provided by Chesapeake Physical Therapy personnel.

Signature: ____________________________________ Date: _________________________

☐ Patient ☐ Legal guardian ☐ Power of attorney