PERFORMANCE PHYSICAL THERAPY AND SPORTS REHABILITATION

5501 Twin Knolls Road, Unit 111
Columbia, MD 21045
Phone: 410-997-2585
Fax: 410-997-2586
www.performanceptandsport.com

Patient History

Patient Name_____Age _____ Today's Date_____

Occupation_____ Dominant hand(circle): R L

Currently Working? Y N Email Address:_____

History of injury / symptoms

Primary complaint _____
Date of injury or problem begin? ___/___/____ Date of Surgery? ___/___/____
What caused your problem to begin? Car accident ____ Work injury ___ Sports injury ____ Not sure ____
Other _____
Have you had any other treatment for this condition? _____
What tests have been done? X-ray____ MRI _____ CAT scan ____ EMG ____
Bone Scan ____ Nerve Conduction ____
Current Medication(s)? _____

Check any other medical conditions you may have:

____ Diabetes	____ Asthma	____ Migraines	____ Currently Pregnant
____ Hypertension	____ Liver Disease	____ Depression	____ Heart Attack
____ Kidney Disease	____ Nervous Disorders	____ Cancer	____ Osteoporosis
____ Seizures	____ Heart Disease	____ Stroke	____ Thyroid Disease

Other : _____
Allergies (please list) _____
Recent surgeries (please list) _____
Do you have a pacemaker or any metal implants? _____

Pain Level

Mark on the scale what level your pain is:

At its **worst**:

0 1 2 3 4 5 6 7 8 9 10
No pain — Makes you stop what you are doing — Worst pain Need to go to E.R.

At its **best**:

0 1 2 3 4 5 6 7 8 9 10
No pain — Makes you stop what you are doing — Worst pain Need to go to E.R.

Where is your pain? Mark on the drawings below the areas where you feel your pain.