

Bradley Physical Therapy Clinic

Patient's Name: _____ Date: _____

Medical History: Do you have any of the following? (Circle Y or N) (or point & click)

High Blood Pressure	Y	N	Heart Disease	Y	N	Diabetes	Y	N	Cancer	Y	N
Lung Disease	Y	N	Pacemaker	Y	N	Metal Implants	Y	N	Pregnant	Y	N
Chest Pain	Y	N	Stomach Problems	Y	N	Loss of Appetite	Y	N	Chills	Y	N
Bowel/Bladder Problems	Y	N	Constipation	Y	N	Diarrhea	Y	N	Dizziness	Y	N
Frequent Sweating	Y	N	Pain swallowing	Y	N	Fatigue	Y	N	Fever	Y	N
Shortness of Breath	Y	N	Gets Full Quickly	Y	N	Headaches	Y	N	Heartburn	Y	N
Female Problems	Y	N	Hoarseness	Y	N	Indigestion	Y	N	Nausea	Y	N
Night Pain	Y	N	Night Sweats	Y	N	Skin Rashes	Y	N	Vomiting	Y	N
Irregular Heart Rate	Y	N	Weakness	Y	N	Numbness	Y	N	Tingling	Y	N
Weight Loss	Y	N	Dieting	Y	N	Vision Changes	Y	N	Cough	Y	N
Cough up Blood	Y	N	Are you contagious	Y	N	Seizures	Y	N	Burning	Y	N
Allergic to Chlorine	Y	N	Allergic to Adhesive Tape	Y	N	Allergic to Iodine	Y	N	Other Allergies _____		
Surgeries	Y	N	(List) _____								

List any medication you are taking: _____

How would you rate your General Health? (Circle One) (or point & click) Poor Fair Good Excellent

List other medical problems: _____

History of Present Problem: (Write, Type or Circle correct answer) or (Circle Y or N) (point & click will circle answer or check box in fill-in pdf form)

What is your current complaint? _____ When did it Start? _____

Due to an injury? (Explain) _____ Illness? _____

Did the symptoms begin: Suddenly or Gradually Previous Problems in this area? Y N

Previous Therapy for this condition? Y N (What Effect _____)

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which ones? _____

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where: _____

What reduces your pain: _____

What can't you do because of your symptoms? _____

Recent Tests: X-Ray CT MRI EMG Myelogram Other _____

Results: _____

What did the Doctor tell you is your diagnosis? _____

Did he put you on any restrictions? List: _____

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain? :

Right now : _____

Your worse pain in past 24 hours : _____

Least pain in past 24 hours : _____

Please color your area of pain on the body diagram

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Office Use Only:
Blood Pressure

