PORTLAND PHYSICAL THERAPY

Account Information

If you need any assistance completing this paperwork, please ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful and educational.

CONFIDENTIAL HEALTH INFORMATION
Clinic ID: Date:

Patient Information

_____ _____ _____

Last name First name MI Date of Birth Age

_____ _____

Referring Physician Primary Care Physician

Health Complaints

What is your chief complaint?_____

_____

When did your symptoms begin?_____

How did you symptoms begin? (i.e. sudden, gradual, MVA, sports injury)_____

Have you had surgery for your chief complaint: ☐Yes ☐No

If yes, list date and procedure(s)_____

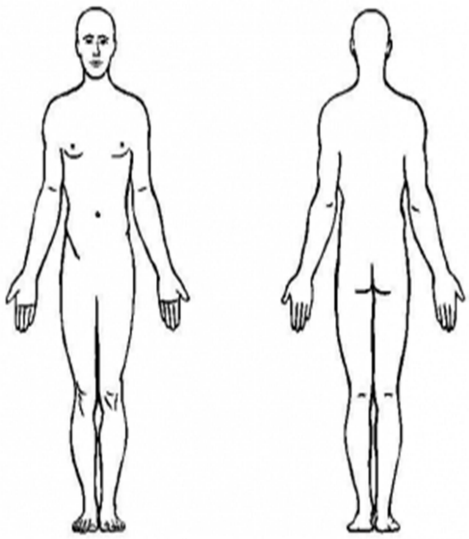
Have you had other treatment(s) for your condition: ☐Yes ☐No

If yes, please explain_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Please use this key to indicate your symptom(s) on the image below: 00 Dull pain; xx sharp pain; == Numbness/Tingling; ^^Burning; // Throbbing.



***Please indicate a number based on the scale below regarding your pain level_____

Pain Scale		
	0	No pain, feel normal.
Minor: Able to adapt to pain.	1 Very Mild	Very light, barely noticeable pain
	2 Discomforting	Minor pain, like light pinch of skin
	3 Tolerable	Noticeable pain, like receiving injection
Moderate: Interferes with daily activities	4 Distressing	Strong, deep pain like tooth ache
	5 Very Distressing	Sharp pain, like ankle sprain
	6 Intense	Sharp pain, like several bee sings
Severe: Unable to function normally	7 Very Intense	Comparable to average migraine headache
	8 Utterly Horrible	Comparable to bad migraine
	9 Excruciatingly Unbearable	Intense pain you cannot tolerate it, need medication
	10 Worst Pain Ever Experienced	Pain so intense, you will go unconscious shortly

Last Name, First Initial:_____

Health History:

Check the box to any of the following that pertains to you:

Cardiovascular			**Pulmonary**			**Other**		
Arrhythmia	☐Yes	☐No	Asthma	☐Yes	☐No	Alcohol Consumption	☐Yes	☐No
Coronary Artery Disease	☐Yes	☐No	COPD	☐Yes	☐No	If yes, how many servings per week:		
Heart Attack	☐Yes	☐No	Persistent Cough	☐Yes	☐No	Allergies	☐Yes	☐No
High Cholesterol	☐Yes	☐No	Shortness of Breath	☐Yes	☐No	If yes, what:		
High/Low Blood Pressure	☐Yes	☐No				Anxiety	☐Yes	☐No
Musculoskeletal			**Neurovascular**			Bruise Easily	☐Yes	☐No
Difficulty Walking	☐Yes	☐No	Bowel/bladder Issues	☐Yes	☐No	Cancer	☐Yes	☐No
Joint Pain	☐Yes	☐No	Dizziness	☐Yes	☐No	Depression	☐Yes	☐No
Joint Stiffness	☐Yes	☐No	Double Vision	☐Yes	☐No	Diabetes Mellitus Type	☐Yes	☐No
Muscle Spasm	☐Yes	☐No	Epilepsy	☐Yes	☐No	Insomnia	☐Yes	☐No
Osteoarthritis	☐Yes	☐No	Fainting spells	☐Yes	☐No	Memory Loss	☐Yes	☐No
Osteoporosis/osteopenia	☐Yes	☐No	Headaches	☐Yes	☐No	Recent Weight Loss	☐Yes	☐No
Integumentary (Skin)			Numbness/Tingling	☐Yes	☐No	Recreational Drug Use	☐Yes	☐No
Increase Sensitivity	☐Yes	☐No	Radiating Pain	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Increased Sweating	☐Yes	☐No	Stroke/TIA	☐Yes	☐No	Tobacco Use	☐Yes	☐No
Nail/Hair Changes	☐Yes	☐No	Weakness	☐Yes	☐No	If yes, how often, how much:		
Rash	☐Yes	☐No				Wear glasses/contacts	☐Yes	☐No

Please list all your current medications with dosage, including over the counter:

☐_____ Dosage_____
☐_____ Dosage_____
☐_____ Dosage_____
☐_____ Dosage_____
☐_____ Dosage_____
☐_____ Dosage_____
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☐_____ Dosage_____
☐_____ Dosage_____

Family Medical History:
Please list all relevant family medical history:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Occupational Information:

Work title/role:_____

Work duties:_____
_____

How many hours a week do you work?_____

Are you currently working: ☐Yes ☐No
If no, when was the last date worked?_____

Is computer use a part of your job: ☐Yes ☐No
If yes, how many hours a day are dedicated to computer use?_____

_____
Signature of Patient Date

_____
Signature of Guardian Relationship to patient Date