PERFORMANCE THERAPY GROUP
PATIENT HISTORY FORM – Page 1

Patient Name: ______________________________ Patient DOB: _________ Date: __________

IF YOU HAVE MORE THAN ONE COMPLAINT, PRINT & COMPLETE THIS PAGE FOR EACH PROBLEM

Present Complaint: ________________________________
____

History of Present Complaint:
When did your most recent problem begin? _________________
How did it begin?
 Immediately after a specific event Multiple events
 Gradually developed No apparent reason
What do you think is causing your problem?:_______________
____
Is your pain constant intermittent only w/ movement
Is your pain improving worsening not changed
Have you had this problem before? Yes No When? _____
What makes your problem better? ________________________
____
What makes your problem worse? _________________________
____
Rate your pain level: **now** ____/10 **At its worst** ____/10
No pain 0 1 2 3 4 5 6 7 8 9 10 Most intense pain imaginable
Is there anything else you feel might be related to this problem?
____
Prior tests: X-ray, MRI, CT, ultrasound, lab, other:__________
____
Prior treatment for this problem?
 None Physical therapy Chiropractic Acupuncture
 Massage Injections Surgery _________________
 Medications (frequency/dosage) __________________
 Other ____________________________________
What have you been told is wrong? ______________________
When was treatment and did it work? _____________________

FOR PROVIDER USE ONLY
______yo_______________♂_♀__________
____
____
____
____
TODAY?__________________________
____
____
____
____
WC/MVA_________________________
____
____
worse_w/_sitting/lifting/morning/____
valsalva/standing/walking/___________
____
____
____
____
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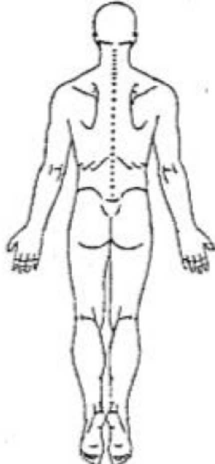
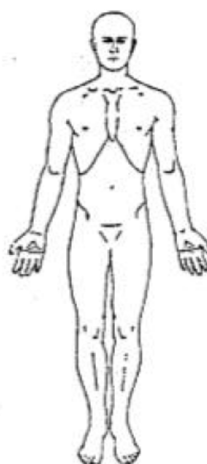
____
____
____
____
GOALS:__________________________
____
CONCERNS:_______________________

Fill out the pain drawing below using the following symbols:
>>>>> Ache Numbness XXXX Burning ///////// Stabbing 000000 Pins & Needles

DDX
CA__________
Fx(stress)_____
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____
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