PERFORMANCE PHYSICAL THERAPY AND SPORTS REHABILITATION

9194 Red Branch Rd, Suite J
Columbia, MD 21045
Phone: 410-997-2585
Fax: 410-997-2586
www.performanceptandsport.com

Patient History

Patient Name_____Age _____ Today's Date_____

Occupation_____ Currently Working? Y N Dominant hand(circle): R L

Phone Number: _____ Email Address: _____

History of injury / symptoms

Primary complaint _____
Date of injury or problem begin? ___/___/____ Date of Surgery if applicable? ___/___/____
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)? _____

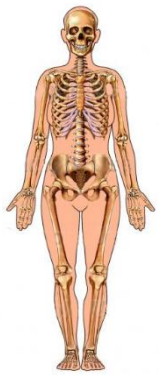
Check any other medical conditions you may have:

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

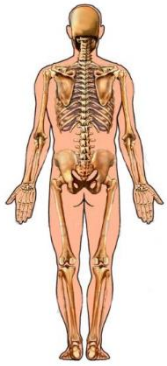
Other : _____
Allergies (please list) _____
Recent surgeries (please list) _____
Do you have a pacemaker or any metal implants? _____

Symptoms:

Mark on the drawings below the areas where you feel your symptoms:



R L



L R

Pain Level

Mark on the scale what level your pain has been:

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.

Symptom Description:

Circle all that apply

Aching	Stabbing	Dull
Radiating	Burning	Cramping
Throbbing	Sore	Numb
Heavy	Weak	

Other: _____