PULLMAN Sports PHYSICAL THERAPY

Mark D. Cleven, PT ATC
Marci Stephens, MPT

Name:_____Date:_____Occupation_____

Referring Physician_____Referred for:_____Age:_____

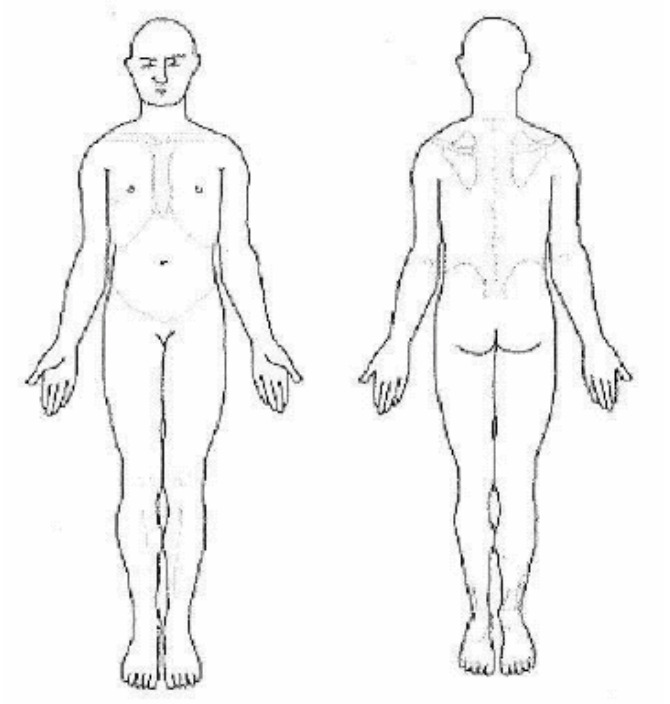
To insure that you receive a complete and thorough evaluation, please provides us with important background information on the following form. If you do not understand the question, your therapist will assist you. Thank you.

HISTORY OF PRESENT CONDITION

What are your symptoms?

_____
_____-
_____

Localize areas of **pain** or **abnormal** sensation on the body chart below (shade in where appropriate)



Pain Scale

On the following scale, mark a line to indicate your level of pain. One is low and 10 is high on the scale.

1_____10

2. When did your symptoms begin? (Please indicate a specific date if possible) _____

3. Was the onset of this episode gradual or sudden? (Check one)
   □ gradual □ sudden

4. Which of the following best describes how your injury occurred? (If you condition is post-surgical please indicate as per original injury)

   □ lifting
   □ MVA (car accident)
   □ a fall
   □ overuse (cumulative trauma)
   □ trauma
   □ degenerative process
   □ during recreation/sports
   □ running
   □ a blow to the head
   □ being hit by a ball
   □ dental appointment
   □ throwing
   □ an incident at work
   □ unknown
   □ per original injury
   □ other

5. Since the onset, are your symptoms getting: (Check one)
   □ better □ worse □ not changing

6. Have you had similar symptoms in the past?
   □ Yes □No
   If "yes', have you had more than one episode?
   □ Yes □No

7. Nature of pain/symptoms (check all that apply)
   □ sharp □ aching □ constant
   □ dull □ periodic □ other _____
   □ throbbing □ occasional _____

8. As the day progresses do your symptoms: (Check one)
   □ increase □ decrease □ stay the same

9. Does the pain wake you at night? □ Yes □ No
   If "yes", is it present
   □ while lying down □ only when changing positions □ both

10. Do you have pain/stiffness upon getting out of bed in the morning?
    □ Yes □ No

11. In what position do you sleep? (Check all that apply)

    □ right side □ back □ other_____
    □ left side □ chair/recliner
    □ stomach □ back, sides, stomach

12. Pillow
    □ Foam □ Down □ Contoured

13. What aggravates your symptoms? (Check all that apply)
    □ sitting
    □ going to/rising from sitting
    □ lying down
    □ walking
    □ up/down stairs
    □ reaching overhead
    □ reaching in front of body
    □ reaching behind back ψ looking up/down
    □ reaching across body ψ looking overhead
    □ household activities including _____
    □ standing
    □ squatting
    □ sleep
    □ coughing/sneezing
    □ taking a deep breath

14. Since the onset of your current symptoms have you had: (Check all that apply)
- □ any difficulty with bowel function
- □ fever/chills
- □ any numbness in the genital or anal area
- □ numbness
- □ any dizziness or fainting attacks
- □ weakness
- □ unexplained weight bladder change
- □ night pain/sweats
- □ malaise (vague feeling of bodily discomfort)
- □ problems with vision/hearing
- □ none of the above

15. What relieves your symptoms? (Check all that apply)
- □ sitting
- □ heat
- □ cold
- □ stretching
- □ wearing a splint
- □ rest
- □ standing
- □ walking
- □ exercise
- □ other_____
- □massage
- □ medication
- □ nothing
- □ lying down

16. Have you had any previous treatment for this condition? (Check all that apply)
- □ none
- □ medication (oral)
- □ joint manipulation
- □ exercise
- □ massage therapy
- □ traction
- □ bracing/taping
- □ injection into the spine
- □ injection into the skin/muscles
- □physical therapy
- □ hypnosis
- □ biofeedback
- □ TENS unit
- □ acupuncture
- □ bed rest
- □ overnight hospitalization
- □ casting
- □ other _____ _____

17. Have you had any of the following tests?
- □ none
- □ x-rays
- □ CT Scan
- □ MRI
- □ Arthrogram
- □ Stress X-ray Test (Telos)
- □ Bone Scan
- □ Nerve Conduction S.
- □ Fluoroscope
- □ Vestibular
- □ other _____ _____

Test Results: _____

PAST MEDICAL HISTORY

Have you ever had/been diagnosed with any of the following conditions? (Check all that apply)
- □ Cancer (type)_____
- □ Depression
- □ Stroke
- □ Kidney problems
- □ Thyroid problems
- □ Diabetes
- □ Multiple sclerosis
- □ Arthritis
- □ Head injury
- □ Stomach problems
- □ Parkinson's disease
- □ Infectious diseases (i.e. hepatitis, tuberculosis, etc.)
- □ Heart problems
- □ High blood pressure
- □ Lung problems
- □ Blood disorders
- □ Epilepsy/seizures
- □ Allergies
- □ Rheumatoid arthritis
- □ Osteoporosis
- □ Broken bone
- □ Circulation/vascular problems
- □ Other _____

Please list any recent/relevant past surgeries related to your current problem:

SURGERY **DATE**

_____
_____
_____
_____

MEDICATION

Are you currently taking any of the following over the counter medications?
- □ aspirin
- □ Tylenol
- □ corticosteroids
- □ antihistamines
- □ vitamins/mineral supplements _____
- □ Advil/ Motrin/ Ibuprofen
- □ glucosamine
- □ other_____

GENERAL HEALTH

How would you rate your general health?
- □ Excellent
- □ Good
- □ Average
- □ Fair
- □ Poor

Do you exercise outside of normal daily activities?
- □ 5+ days/wk
- □ 3-4 days/wk
- □ 1-2 days/wk
- □ occasionally
- □ zero

Exercise, Sports/Recreation consisting of _____
_____

Do you drink caffeinated beverages?
□ No □ Yes How many/much per day_____

Do you smoke?
□ No □ Yes Packs of cigarettes per day_____

What is your stress level?
□ Low □ Medium □ High

Are you seeing any health care providers other than the physical therapist for this current condition? (Please list)
_____
_____
_____
_____

WORK HISTORY

Occupation_____
- □ employed full time
- □ employed part time
- □ self employed
- □ homemaker
- □ student
- □ retired
- □ unemployed
- □ other_____

Physical activities at work (check all that apply)
- □ sitting
- □ standing
- □ phone use
- □ repetitive lifting
- □ heavy lilting
- □ computer use
- □ heavy equipment operation
- □ driving
- □ other_____

Are you currently receiving or seeking disability for this condition?
□ Yes □ No

FAMILY HISTORY

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for or diagnosed with any of the following?
- □ Diabetes
- □ Heart Disease
- □ High blood pressure
- □ Stroke
- □ Cancer
- □ Arthritis
- □ Osteoporosis
- □ Psychological condition