Marina Physical Therapy

Date:__________

Patient History

Name:________________________________ Date of Birth:__________________________
Referring Physician:_____________________ Date of Injury:__________________________
Occupation:____
Injury Description:____
____

Past Medical History:

- ❑Allergy/Asthma
- ❑Seizures/Epilepsy
- ❑Heart problems
- ❑Stroke/TIA
- ❑Skin Problems
- ❑Thyroid Problems
- ❑Fibromyalgia
- ❑Emphysema/COPD
- ❑Mitral Valve Prolapse
- ❑Blood Clots/Phlebitis
- ❑Essential Tremor
- ❑Osteoporosis
- ❑Osteopenia
- ❑Osteoarthritis
- ❑Angina
- ❑Cancer
- ❑Migraine
- ❑Depression
- ❑Anxiety
- ❑Diabetes
- ❑Head Injury
- ❑Reflex Sympathetic Dystrophy
- ❑Infectious Disease (TB, hep, HIV)
- ❑High/low blood pressure
- ❑Psychiatric Disorders
- ❑Urinary/kidney problems
- ❑Rheumatoid Arthritis
- ❑Women: Are you Pregnant

Other:____
Past Orthopedic Injuries, Surgeries Dates:______________________________________
____
Current Medications:____
____
Physical Activity/Exercise Routine: Type:_______________________________________
How often:_____________________**Time Spent:**_________________**Currently able to continue?**_____________
Goal: What would you like to gain from physical therapy?_____________________________
____

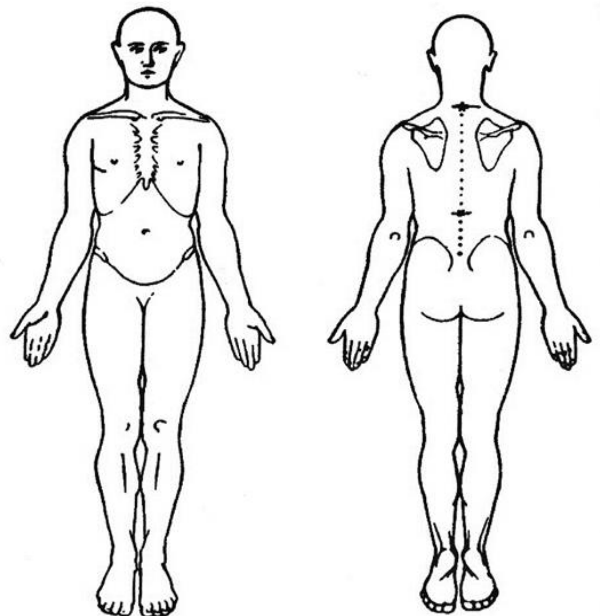
Current Symptoms:

- ❑Shortness of breath
- ❑Fever/Night sweats
- ❑Fatigue/Weakness
- ❑Dizziness
- ❑Balance/Coordination Changes
- ❑Numbness/Tingling
- ❑Swelling of Ankles/Hands
- ❑Bowel Bladder Problems
- ❑Vision Problems
- ❑Headaches
- ❑weight Loss/Gain
- ❑Nausea/Vomiting

Please mark using symbols

Symptoms:

X Sharp Pain
∘∘∘ Numbness, Tingling
/// Ache
ΔΔΔ Burning



Rate the intensity of your pain (Best and Worst).

	0	1	2	3	4	5	6	7	8	9	10
At Rest	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Minimal			Moderate							Severe
Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
	Minimal			Moderate							Severe