College Park Physical Therapy

# Physical Therapy & Functional History

Name:____________________ Age:________ Physician:____________________

What are we seeing you for today? ______________________________

Specific date of injury/onset of symptoms: (mm/dd/yy) ____________

How did it occur? ______________________________

List any previous treatments for this episode: ____________________

Notes:

Do you have: **Female** (Please check)

- ☐ Urinary or fecal incontinence
- ☐ Painful intercourse
- ☐ Prolapse
- ☐ Pain inserting tampons
- ☐ Pain with sitting
- ☐ Difficulty emptying bladder
- ☐ Constipation
- ☐ Urinary urgency/frequency

**Male** (Please check)

- ☐ Urinary or fecal incontinence
- ☐ Scrotal pain/Urinary
- ☐ Numbness/tingling of genitalia
- ☐ Tailbone pain
- ☐ Stop/start flow of urine
- ☐ Constipation
- ☐ Urinary urgency/frequency

Any recent health changes (i.e. significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc?)

________________________________________

Any allergies to tape/medications/latex? (List) ____________________

Have you had any of the following tests for this specific incident?

☐ CT Scan ☐ MRI ☐ X-Ray ☐ EMG ☐ Bone Scan ☐ Other

1. Have you had physical therapy for this problem before? Yes ☐ No ☐ When?______
2. Have you had any falls in the past year? Yes ☐ No ☐ When?______
3. Have you been hospitalized in the last year? Yes ☐ No ☐ When?______
4. Are you currently being treated by another healthcare provider? Yes ☐ No ☐ Who? ______
5. What was your level of activity prior to your injury? (Check one) ☐ High ☐ Moderate ☐ Low
6. What was your level of fitness prior? (List activities) ____________________
7. What is your current level of fitness? (List activities) ____________________
8. Are you currently working? ☐ Full time ☐ light duty ☐ off ☐ homemaker ☐ N/A
9. What is your occupation? ____________________
10. What does it require? (Please check)

☐ lifting ☐ pushing/pulling ☐ writing ☐ walking ☐ computer/typing
☐ twisting ☐ kneeling/crouching ☐ standing ☐ carrying ☐ sitting
☐ climbing ☐ repetitive movements ☐ reaching ☐ other

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# Physical Therapy & Functional History cont.

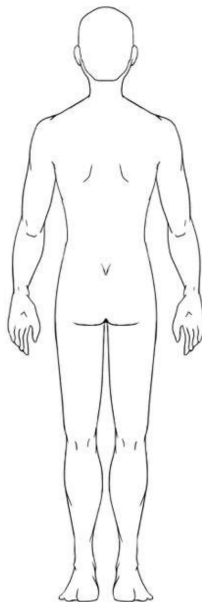
11. When is your next doctor appointment? ____________ With Whom? ____________

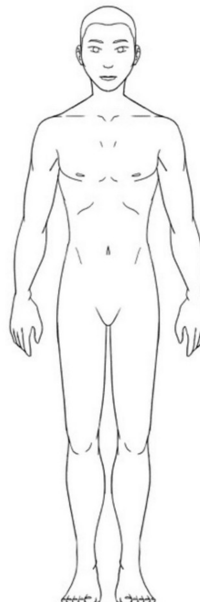
12. List goals you would like to achieve with coming to therapy

13. My pain is: ☐ aching ☐ burning ☐ stabbing ☐ pins and needles ☐ dull ☐ sharp ☐ other: ____________

14. Use the following drawing and symbols shown to indicate the location and type of symptoms you are experiencing at the present time:

| Sharp Pain | Achiness | Burning | Pins & Needles | Numbness |
|---|---|---|---|---|
| / / / / / | XXXXX | ! ! ! ! ! | 0 | +++++ |





15. Is your pain worse in the (Please check) ☐ Morning ☐ Afternoon ☐ Evening

16. Is your pain (Please check) ☐ Constant ☐ Come and go

17. What makes your pain worse? ____________

18. What eases your pain? ____________

PRINTED Patient Name ____________ Patient Signature ____________ Date ____________

Therapist Signature ____________ Date ____________