OPTIMAL PHYSICAL THERAPY & PERFORMANCE INSTITUTE

1 Anderson Rd, Suite 104 Bernardsville, N.J 07924

Phone: 908-696-8900 Fax: 908-696-8902

Patient History / Problem List

Patient Name:_____ Date:_____
Date of Birth:_____/_____/_____ Physician:_____
Initial Eval:_____
Date of Next .Physician Visit? _____/_____/_____

A. Personal Medical History

1. Please Circle all conditions which you have or have had in the past:

Allergies
Angina/chest pain
Arthritis
Asthma/breathing disorders
Back pain
Blood disorders
Bowel/bladder disorder
Cancer_____
Diabetes
Dizziness/fainting
Eating disorders
Epilepsy/seizures
Fractures
Head aches
Hearing difficulty
Heart conditions/disease
Hepatitis
Hernia
High blood pressure
HIV positive
Hypoglycemia
Kidney disease
Liver/gallbladder disease
Lyme disease
Meningitis
Multiple Sclerosis
Neuritis
Osteoporosis
Pacemaker
Parkinson's Disease
Phlebitis
Pregnant
Ringing in ears
Stroke
Tuberculosis
Other_____

2. Allergies (specify):_____

3. Medications:_____

4. Implants(metal/plastic):_____

5. Diagnostic tests/procedures:_____
_____

6. Surgeries:_____
_____

Pt. Name:_____ Birthdate:_____

B. Medical History

1. Date of injury/ start of symptoms:____/____/____

2. Have you ever had these symptoms before? Y *I* N

3. Do you currently have pain? Y / N

4. How would you rate your pain?

(0 = no pain 5 = moderate pain 10 = severe pain)

At Best: 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10

At Worst: 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10

5. Does anything make your pain better? _____

6. Does anything make your pain worse?_____

7. Please indicate where your symptoms are located. _____

8. Circle which apply to your symptoms:

work related	recurrence of previous injury
related to fall	motor vehicle accident
athletic/recreational	related to lifting
daily activities	other:_____

9. Have you had a related surgery? Y / N

10. Are you presently employed/working? Y / N

11. Do you plan on returning to work? Y / N

12. What was your level of daily activity prior to current symptoms/injury?

independent required assistance dependent

13. What are your current problems and goals for therapy?

_____

_____

_____

Signature Relationship to patient Date