Physical Therapy Center

45A Washington Ave • Carteret NJ 07008
Tel: (732) 969-3480

MEDICAL HISTORY

Name _____ Date of Birth _____ Sex_____ Age_____
Currently Working? Yes ☐ No ☐ Height: _____ Weight:_____
Occupation _____ Disability? Yes☐ No☐ Short Term☐ Permanent ☐
Describe Work Duties _____

Your chief complaint for physical therapy? Why are you here? Describe in detail:
_____
_____
_____
Onset of Symptoms_____
Date of Injury _____ Cause of Injury? Motor vehicle accident ☐ Fall ☐ Work Related ☐
Was injury due to trauma? If yes describe _____
Was injury due to over use? If yes describe _____
Has this been a chronic injury? Yes ☐ No ☐ Did this injury happen in the last 2 weeks? Yes ☐ No ☐

Please describe your pain level 0 (no pain) to 10 (emergency room) _____
Is your pain constant ☐ or comes and goes throughout the day ☐
Is your pain (check all that apply): Deep ☐ Superficial ☐ Sharp ☐ Dull ☐ Burning ☐ Aching ☐
Stabbing ☐ Numbness ☐ Burning ☐ Other:_____
Is there any pain radiating from source to extremities? Yes ☐ No ☐
Is there unexplained night pain? Yes ☐ No ☐ Unable to relieve? Yes ☐ No ☐
Does it wake you up at night? Yes ☐ No ☐ When is pain more prevalent? Morning ☐ Night ☐
What makes symptoms go away? Positions that help? _____
What increases symptoms? Positions that hurt? _____

Please describe all past medical history: _____
_____
Please list all past surgical history: _____
_____
Have you had any radiological testing: XRay, MRI, CT Scan, etc.? _____
Please list all medications for all medical history:_____

Describe home setting: Live alone ☐ Stairs ☐ How many _____ Other _____

Exercise level?	None ☐	Moderate ☐	Daily ☐	Heavy ☐
Social life?	Smoking ☐	Alcohol ☐	Coffee/Caffeine ☐	High stress level ☐
Pregnant?	Yes ☐	No ☐		

What goals would you like to achieve in physical therapy? _____
_____

Patient Signature _____ Date _____