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## ADULT PHYSICAL THERAPY CASE HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Please describe the problem(s) for which you seek physical therapy \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did the problem(s) begin (date)? \_\_\_\_\_  
 Have you ever had the problem(s) before? (circle) Yes No If yes, please describe: \_\_\_\_\_

Have you ever received physical therapy or any other treatment for this condition? Yes No  
 If yes, what type and where? \_\_\_\_\_  
 \_\_\_\_\_

Please check if you have ever had:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis / Gout         | <input type="checkbox"/> Low blood sugar      | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Broken bones / fractures | <input type="checkbox"/> osteoporosis         | <input type="checkbox"/> Head injury        |
| <input type="checkbox"/> Kidney problems          | <input type="checkbox"/> Blood disorders      | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood disorders          | <input type="checkbox"/> Circulation problems | <input type="checkbox"/> Heart problems     |
| <input type="checkbox"/> Neurological problems    | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Seizures           |
| <input type="checkbox"/> High blood pressure      | <input type="checkbox"/> Skin diseases        | <input type="checkbox"/> Lung problems      |
| <input type="checkbox"/> Developmental delay      | <input type="checkbox"/> Stroke               | <input type="checkbox"/> Thyroid problems   |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Cancer               |   |

Please explain any box checked above: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Since this problem(s) began, have you had any of the following symptoms? (Check all that apply)

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Chest pain               | <input type="checkbox"/> Difficulty walking      | <input type="checkbox"/> Urinary problems    |
| <input type="checkbox"/> Heart palpitations       | <input type="checkbox"/> Joint pain or swelling  | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Pain at night            | <input type="checkbox"/> Headaches               | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Hearing problems         | <input type="checkbox"/> Loss of appetite        | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Vision problems          | <input type="checkbox"/> Dizziness or blackouts  | <input type="checkbox"/> Bowel problems      |
| <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Loss of balance / falls | <input type="checkbox"/> Weight loss / gain  |
| <input type="checkbox"/> Other: _____             |  |  |

If female, are you currently pregnant? (circle) Yes No

Have you ever had surgery? (circle) Yes No If yes, please describe and include dates: \_\_\_\_\_

List any medications you are presently taking (prescription and non-prescription): \_\_\_\_\_

List any allergies, including medications: \_\_\_\_\_

Have you had any testing done recently (for example, x-rays, MRI, blood tests, etc)?

Yes No

If yes, what were the results? \_\_\_\_\_

Do you smoke? Yes No If so, how much? \_\_\_\_\_

Do you exercise regularly? Yes No If yes, what type and how often? \_\_\_\_\_

Do you use any special supports or devices?

- |   |                                   |                                     |
|---|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> Back cushion, neck cushion                       | <input type="checkbox"/> Crutches | <input type="checkbox"/> Wheelchair |
| <input type="checkbox"/> Back brace, corset                               | <input type="checkbox"/> Cane     | <input type="checkbox"/> Walker     |
| <input type="checkbox"/> Other kind of brace or support for any body part |                                   |                                     |

List any other special devices you are currently using: \_\_\_\_\_

Has the current condition for which you are seeking therapy affected your ability to perform any of the following? Please check all that apply:

- |  |   |                          |
|--|---|--------------------------|
| <input type="checkbox"/> Personal care (bathing, dressing, grooming) | <input type="checkbox"/> Lifting, bending, kneeling, stooping | <input type="checkbox"/> |
| <input type="checkbox"/> Getting in / out of bed, chair, car         | <input type="checkbox"/> Pushing / pulling                    |                          |
| <input type="checkbox"/> Sleep                                       | <input type="checkbox"/> Specific job duties _____            |                          |
| <input type="checkbox"/> Sitting                                     | <input type="checkbox"/> Family / Home responsibilities       |                          |
| <input type="checkbox"/> Standing                                    | (shopping, cooking, child care, etc.)                         |                          |
| <input type="checkbox"/> Walking                                     | <input type="checkbox"/> Running / jumping                    |                          |
| <input type="checkbox"/> Climbing stairs                             | <input type="checkbox"/> Leisure / Recreational activities    |                          |
| <input type="checkbox"/> Driving                                     | <input type="checkbox"/> Other _____                          |                          |

How do you learn best? (circle) Reading Listening Demonstration Other \_\_\_\_\_

Do you have any customs or religious beliefs or wishes that might affect your care? \_\_\_\_\_