KIMA | CENTER FOR PHYSIOTHERAPY & WELLNESS

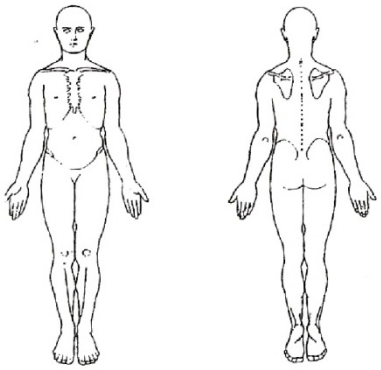
PHYSICAL THERAPY PATIENT HISTORY

NAME: DOB:

REFERRED BY:

WHAT IS YOUR CHIEF COMPLAINT?:

PLEASE USE THE PICTURE BELOW TO INDICATE THE AFFECTED AREAS



RATE YOUR CHIEF COMPLAINT IN ORDER OF SEVERITY FROM **1**- LEAST TO **10**-WORST

PAIN ☐ LOSS OF MOTION ☐ SWELLING ☐ STIFFNESS ☐ LOSS OF FUNCTION ☐

WHEN DID THE PROBLEM BEGIN?:

HAS THIS PROBLEM AFFECTED YOUR DAILY LIFE? (JOB/EXERCISE):

HAVE YOU HAD PREVIOUS OR SIMILAR OCCURRENCES OF THESE SYMPTOMS: YES ☐ NO ☐
IF YES, PLEASE DESCRIBE:

DATES OF SPECIAL TESTS (MRI, XRAY) AND FINDINGS:

PAST MEDICAL HISTORY WITH DATES (ACCIDENTS, INJURIES, FALLS, SURGERIES):

CURRENT MEDICATIONS:

WHAT ARE YOUR CURRENT PHYSICAL ACTIVITIES AND HOW HAVE THEY CHANGED?:

WHAT ARE YOUR GOALS AND EXPECTATIONS OF PHYSICAL THERAPY?: