

**STOVER PHYSICAL THERAPY
NEW PATIENT HEALTH HISTORY**

Patient's Name: _____ Today's Date: _____

What are your personal goals or outcomes you hope to achieve from Physical Therapy?

1. _____
2. _____
3. _____

Please list your current medication: _____

Please give relevant medical and/or surgical history: _____

Is your condition accident related? Yes ____ No ____ if yes, date of injury: _____

Please describe your symptoms. _____

When did symptoms start? _____ How did symptoms begin? _____

How often do you experience your symptoms?

- | | |
|--------------------------------------------|---------------------------------------------|
| a. Constantly (76-100% of the day) | b. Frequently (51-75% of the day) |
| c. Occasionally (26-50% of the day) | d. Intermittently (0-25% of the day) |

How are your symptoms changing? **a.** Getting better **b.** Not changing **c.** Getting worse

During the past 4 weeks:

Indicate the average intensity of your symptoms: (none) 0 1 2 3 4 5 6 7 8 9 10 (unbearable)

How much has pain interfered with your normal work (including both outside the home and housework)?

- a.** Not at all **b.** A little bit **c.** Moderately **d.** Quite a bit **e.** Extremely

How much of the time has your condition interfered with your social activities?

- a.** None of the time **b.** A little bit of time **c.** Some of the time **d.** Most of the time **e.** all of the time

Have you been bothered by feeling down, depressed, or hopeless? Yes ____ No ____

Have you been bothered by little interest or pleasure in doing things? Yes ____ No ____

Who have you seen for your symptoms?

- a.** No one **b.** Medical Doctor **c.** Chiropractor **d.** Other Physical Therapist **e.** Other _____

What treatment did you receive? _____ When? _____

What tests have you had for your symptoms and when were they performed?

- a.** X-rays date: _____ **b.** MRI date: _____ **c.** CT Scan date: _____ **d.** Other date: _____

Patient's Signature: _____ Date: _____