BodyWorks Physical Therapy
Orthopedic & Sports Rehab

Confidential Patient Case History

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU!

Full Name _____**Nickname**_____ **Birthday** _____ **Sex:** ❑**M** ❑**F**

Address:_____ **City** _____ **State**_____ **Zip**_____

Home Phone:_____ **Cell Phone:** _____**Work Phone:**_____ **Ext.**_____

Soc. Sec. #_____ **Marital Status:** ❑**M** ❑**S** ❑**D** ❑**W**

EMAIL ADDRESS: _____

Occupation _____ **Employer** _____

Emergency Contact Name/Relation:_____**Phone#**_____

How did you hear about BodyWorks?_____

What is your major complaint/restriction(s)? _____

_____

Is this condition: ❑**Job related** ❑**Auto Accident** ❑**Other:**_____ **Date of accident** ____/____/____

Date of Onset/Condition? _____**What caused this condition?** _____

Does anything make this condition feel worse? _____

Does anything make this condition feel better? _____

Is this condition interfering with your: ❑**Work/School** ❑**Sleep** ❑**Daily Routine** ❑**Other:**_____

Is this condition: ❑**Improved** ❑**Unchanged** ❑**Getting Worse**

Other Doctors or Therapist who have treated <u>THIS</u> Condition (Please Provide Names)_____

Prior to this injury/problem did you have limitations with your daily activities? Y / N (circle) If yes, please explain.

_____

Do you have a primary doctor? ❑**Yes** ❑**No** **If Yes, Name:** _____

Medications, dosage and frequency (or copy):_____

_____

Have you had this or similar conditions in the past? ❑**Yes** ❑**No** **If Yes, when?**_____

Have you previously been in an auto accident or had any other personal injury? ❑**Yes** ❑**No**
Please Describe: _____

⟹ **Patient Signature**_____**Date** _____
(Parent / Guardian if younger than 18 years old)

HISTORY

High blood pressure	❑	**Controlled Y / N**	**Infectious Disease**	❑	**_____**
Epilepsy/Seizures	❑	**Last Sz_____**	**Dizziness/ fainting**	❑	**_____**
Cancer	❑	**Type_____**	**Bowel/ bladder problems**	❑	**_____**
Depression/Mental Illness	❑	**_____**	**Severe Headaches**	❑	**days/week_____**
Heart attack/Stroke	❑	**date_____**	**Osteoporosis**	❑	**controlled? Y / N Meds?**
Diabetes	❑	**Type I / II Control Y / N**	**Chest Pain**	❑	
Asthma	❑	**last attack?_____**	**Smoking**	❑	**_____ppd _____years**
Severe Allergies	❑	**to?_____epi pen?Y/N**	**Pace Maker**	❑	
Drug/ Alcohol Abuse	❑	**_____**	**Blood clots**	❑	**when/where?_____**

ADDITIONAL MEDICAL HISTORY

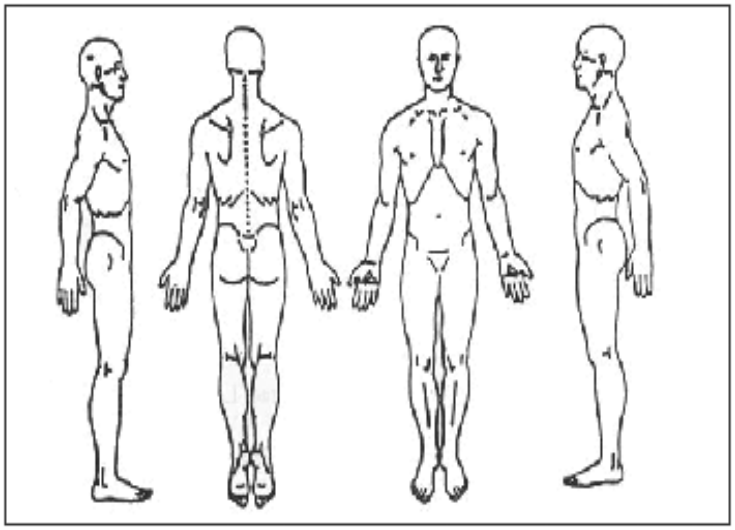
Surgeries/dates_____

Xrays/MRI__**Y**__/__**N**___Results?(**if known**)_____

Recent Hospitalization/ Other?_____

Current Weight_____ **Current Height**_____

Females only: Are you pregnant, planning a pregnancy or nursing a child? ❑Yes ❑No



MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURE TO THE LEFT
!=stabbing, *=aching, //=burning, #=numb/tingling

What is the intensity of your pain from 0-10
"0" = no pain, "10" = emergency room / Most Severe

How bad are your symptoms now? ___/10
How bad have they been in the past week? ___/10

What is the least pain in the past week? ___/10

Worst Activity?_____

Night Pain Y / N ? Hours Sleep Disturbed?____

What are your goals for physical therapy? _____

One activity you'd love to do that you can't do now?_____

PRIMARY INSURANCE / SECONDARY INSURANCE

Insurance:_____
ID#_____**Group#**_____
DOB:_____/___/____
Card Holder's Name:_____
Relationship to patient: ❑Self ❑Spouse ❑Child
Social Security Number:_____

Insurance:_____
ID#_____**Group#**_____
DOB:_____/___/____
Card Holder's Name: _____
Relationship to patient: ❑Self ❑Spouse ❑Child
Social Security Number:_____

⇨

Patient Signature_____**Date** _____
(Parent / Guardian if younger than 18 years old)