MIKE KELO PHYSICAL THERAPY, PLLC
PATIENT HISTORY QUESTIONNAIRE

Patient Name_____ Today's Date_____

Age_____ Height_____ Weight_____ Occupation_____

Please describe your condition and how it began_____

_____

_____

Date Problem began:_____ Date of Surgery(if applicable):_____

Your goals for therapy_____

_____

Have you been in PT or home therapy before? No Yes When?_____
Will your cultural or spiritual beliefs affect your participation in therapy? Yes No

If yes, please explain:_____

Preferred method of learning (circle all that apply): Reading Hearing Visual
Are there factors that will affect your ability to learn from your therapist? (vision, hearing, language, other_____)

Yes or No If Yes, please explain:_____

Highest grade completed? _____
Please circle all of the conditions that apply to you:

High blood pressure	Neurological disease	Pregnancy	Recent Fractures	Osteoporosis
Heart disease	Stroke	Back problems	Fibromyalgia	Incontinence
Pacemaker	Seizures	Neck problems	Chronic Fatigue	Skin sensitivity
Diabetes	Muscle disease	Balance problems	Myofascial pain	Skin Conditions
Stomach Problems	Respiratory disease	Increased fall risk	Speech problems	Cancer
Kidney disease	Asthma	Dizziness	Hearing loss	Tuberculosis

Other, please describe (include allergies):_____

Known or suspected allergies: _____
Are you allergic to latex products? Yes No
Your current medications: _____

_____

Please circle the tests you have had recently: X-ray MRI Arthrogram CT Scan Myelogram EMG Cardiac tests
Nerve conduction velocity Blood tests Thyroid panel Other tests: _____

Have you been experiencing pain recently? Yes No
If Yes, please describe your recent and or current pain problems: _____

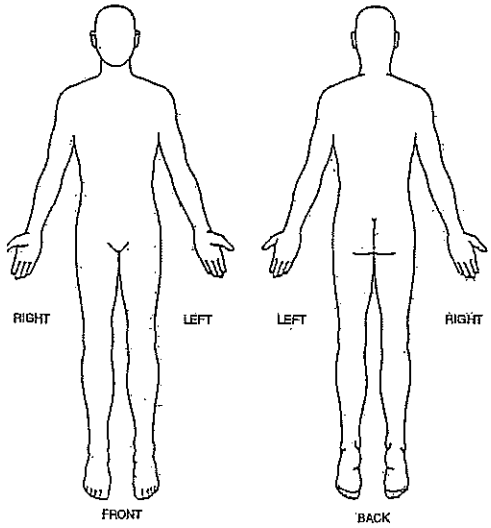
_____

_____

_____

(Please Continue Pain Description on Back of Form)

Shade in the area(s) where you are currently having pain:



Please use the scale below to rate the intensity of current pain for each location by describing the location and then entering a number on the appropriate line to indicate your pain NOW, at its WORST, and at its LEAST. Then, please answer the following questions about each site of pain.

None 0 1 2 3 4 5 6 7 8 9 10 Most severe

Location_____ (use number scale below) Pain Now _____ Pain at Worst _____ Pain at Least _____	Location_____ (use number scale below) Pain Now _____ Pain at Worst _____ Pain at Least _____	Location_____ (use number scale below) Pain Now _____ Pain at Worst _____ Pain at Least _____
The Pain Feels (circle): Sharp Dull Cold Burning Stabbing Throbbing Shooting Radiates to:_____	The Pain Feels (circle): Sharp Dull Cold Burning Stabbing Throbbing Shooting Radiates to:_____	The Pain Feels (circle): Sharp Dull Cold Burning Stabbing Throbbing Shooting Radiates to:_____
Frequency: Constant Daily Intermittent	Frequency: Constant Daily Intermittent	Frequency: Constant Daily Intermittent
What relieves pain?	What relieves pain?	What relieves pain?
What aggravates Pain?	What aggravates Pain?	What aggravates Pain?
Previous Treatment for this Pain:	Previous Treatment for this Pain:	Previous Treatment for this Pain:

FOR THERAPIST USE ONLY (evaluation findings, including additional pain sites)
Have reviewed contents of form and discussed with the patient: Yes No

Pain or Education Materials Provided? Yes No	Resting Vitals: BP	HR	RR