New Patient History - Jeff Rau R&R Physical Therapy

Welcome to our practice!

Please help us serve you better by taking a few minutes to provide the following information. Please fill out these forms as specifically as possible to provide us with a clear picture of your present condition.

1. Last Name: ____ First Name: ____ DOB: ____ Age: ____

   Address: ____

   City: ____ State: ____ Zip: ____

   Mobile Phone: ____ Home Phone: ____ Work Phone: ____

   Marital Status:
   ○ Married ○ Single ○ Widowed ○ Divorced

   Email: ____

   Occupation ____

   Employer: ____

   Emergency Contact's Name & Phone Number ____

   Primary Physician's Name: ____

   Specialist Physician's Name: ____

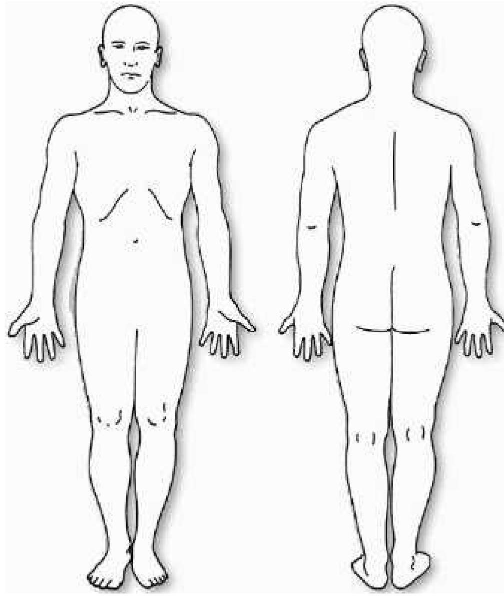
2. **How did you hear about our practice?**

   ____

3. **Whom can we thank for referring you to our practice?**

   ____

4. Please draw the areas where you have pain, discomfort, or tension.



5. What is the primary issue/problem that brings you in today?

____
____
____
____

6. Secondary concern/problem?

____
____
____
____

7. What are you unable to do or having difficulty doing now because of this problem?

____
____
____
____

8. Are you currently experiencing pain as a result of these symptoms?

- ○ Yes
- ○ No

9. If yes, what is it like? Why do you think you are in pain? What do you think is the cause?

____

10. What is your biggest concern?

____

11. **When did your symptom(s) begin? (Date):**

____

____

____

____

12. **Please rate your pain in the last 24-72 hours - using the “0 -10” scale where 0 is no pain and 10 is the worst possible pain:**

At its worst:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

At its best:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

At present:
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

Night (sleeping):
○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10

13. At what time of day are your symptoms the worst? _______________

At what time of day are your symptoms the best? _______________

What activities increase your pain?

____

What activities decrease your pain?

____

14. **What other types of treatment have you had for this problem?**

- ☐ Massage
- ☐ Bodywork
- ☐ Physical Therapy
- ☐ Myofascial Release
- ☐ Chiropractic
- ☐ Surgery
- ☐ Injections
- ☐ Other Medical Treatment

If "other", please specify

____

15. **Check the box if you have had any of the following medical conditions:**

- ☐ Diabetes
- ☐ Lung disease
- ☐ Recent Weight change
- ☐ Varicose Veins
- ☐ Neurological problems
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Osteoporosis
- ☐ Migraine Headaches
- ☐ Epilepsy / Seizures
- ☐ Stroke
- ☐ Blackouts
- ☐ Heart Murmur
- ☐ Malignancy
- ☐ Arthritis
- ☐ Broken Bones (fracture)
- ☐ Metal Implants
- ☐ High Blood Pressure
- ☐ Circulatory Problems
- ☐ Liver Disease
- ☐ Heart Disease / Pacemaker
- ☐ Kidney Disease
- ☐ Cosmetic Implants/Enhancements
- ☐ Other(s)

If "other(s)", please specify

____

16. List past medical history and dates of occurrence. Include surgeries, accidents and other traumas.

____

____

____

____

17. List ALL medications which you are currently taking, the condition for which you are using them, the dose, and their effectiveness. (Include supplements, herbal and homeopathic remedies).

	Medication	For treatment of	Dose / Amount per day	Effectiveness
1				
2				
3				
4				

18. Do you smoke? If “yes”, how much?

____

19. When did you quit? If not, Would you like to quit?

____

20. Is there a chance you may be pregnant at this time?

- Yes
- No

21. Do you engage in regular exercise?

- Yes
- No

22. What type and how often?

____

23. Are you able to exercise now?

- Yes
- No

24. Do you have discomfort, shortness of breath, or pain with exercise? If "yes", please describe.

____

25. In general, your lifestyle is (1 - Active / 3 - Average / 5 - Inactive)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

26. If sleep is a problem, answer these questions:

Do you have trouble falling asleep?
○ Yes ○ No

Is your sleep restful?
○ Yes ○ No

Do you find it difficult to lie down?
○ Yes ○ No

Do you find it difficult to change positions in bed?

____

How many times do you wake in the night?

____

How long before you fall back to sleep?

____

27. **List all the Tasks / Activities that you have difficulty performing and your tolerance (minutes/hours).If you are no longer able to perform an activity, your tolerance would be "0".**

	Task / Activity	Tolerance (minutes/hours)
1		
2		
3		
4		

28. **Patient Goals Please list the activities that you would like to be able to do as a result of therapy.**

	Task / Activity	Duration / How Often	By When
1			
2			
3			
4			

29. **What is the #1 activity you really want to be doing but you are not? For example, if I could magically snap my fingers and change your body, how do you want it to be? Is there a certain activity that you want to be able to do?**

____

____

____

____

______________________________ Signature

______________________________ Date