# Confidential Patient Case History

Please complete this questionnaire in its entirety. This confidential medical history will be part of your permanent records. Provide as much detail as possible to provide your therapist with a comprehensive overview of your case and present condition. Thank you!

**Patient's Full Name ________________________________________Nickname_______________ Birthday __________**

**How did you first hear about Synergy?**
○ Workshop ○ Email ○ Physician ○ Workman's Comp ○ Website ○ Facebook ○ Friend/Family____________________

**Address:__________________________________________ City ________________________ State_____ Zip________**
**Home Phone:____________________ Cell Phone: ________________Work Phone:_________________ Ext.________**
**EMAIL: _______________________________________________________ May we leave a voice message? ❑Yes ❑No**
**Social Security Number:____________________________ Marital Status: ❑M ❑S ❑D ❑W ❑P Sex: ❑M ❑F**
**Occupation: __________________________________________ Employer:_____________________________________**
**Emergency Contact Name/ Relation: __________________________/__________________Phone#:________________**
**Please list anyone in which we have permission to speak to regarding treatment or scheduling:___________________**

## MEDICAL HISTORY

**Describe in detail, what is your major complaint/ restriction(s)?___________________________________________**

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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

**Date of onset? ____________What caused/ preceded this condition? ______________________________________**

**Does anything make this condition feel worse? ___________________________________________________________**

**Does anything make this condition feel better? ___________________________________________________________**

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

**Is this condition: ❑Improving ❑Unchanging ❑Getting Worse ❑ Intermittent**

**Other Doctors or Therapist who have treated THIS Condition** (Please Provide Names)**:___________________________**

**Prior to this injury/problem did you have limitations with your daily activities? ❑Yes ❑No If YES, please explain:**

_____________________________________________________________________________________________

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

**REQUIRED BY INSURANCE:**

| **Medication** | | | | | |
|---|---|---|---|---|---|
| **Dose** | | | | | |
| **Frequency** | | | | | |

**Have you had this or similar conditions in the past? ❑Yes ❑No If YES, what date(s)?________________________**

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

**If YES, please list YEAR/ INJURIES:______________________________________________________________**

**Are you receiving or have you recently received other therapy services for this condition? ❑Yes ❑No**

## FAMILY & SELF HISTORY

| | Self | Father | Mother | | | Self | |
|---|---|---|---|---|---|---|---|
| High blood pressure | ☐ | ☐ | ☐ | Controlled? Y / N | Infectious Disease | ☐ | |
| Epilepsy/Seizures | ☐ | ☐ | ☐ | Last:____________ | Dizziness/ fainting | ☐ | |
| Cancer | ☐ | ☐ | ☐ | Form:___________ | Bowel/ bladder problems | ☐ | |
| Depression/Mental Illness | ☐ | ☐ | ☐ | | Severe Headaches | ☐ | Days/Week_____________ |
| Heart attack/Stroke | ☐ | ☐ | ☐ | Date:__________ | Osteoporosis | ☐ | Controlled? Y/N |
| Diabetes | ☐ | ☐ | ☐ | Type I/II | Chest Pain | ☐ | |
| Asthma | ☐ | ☐ | ☐ | Last Episode:_____ | Smoking | ☐ | Ppd_____ Years_________ |
| Drug/ Alcohol Abuse | ☐ | ☐ | ☐ | | Pace Maker | ☐ | |
| Severe Allergies | ☐ | ☐ | ☐ | To:____________ | Blood clots | ☐ | When/Where?___________ |

Please clarify any above checks: ____________________________________________________________

____________________________________________________________

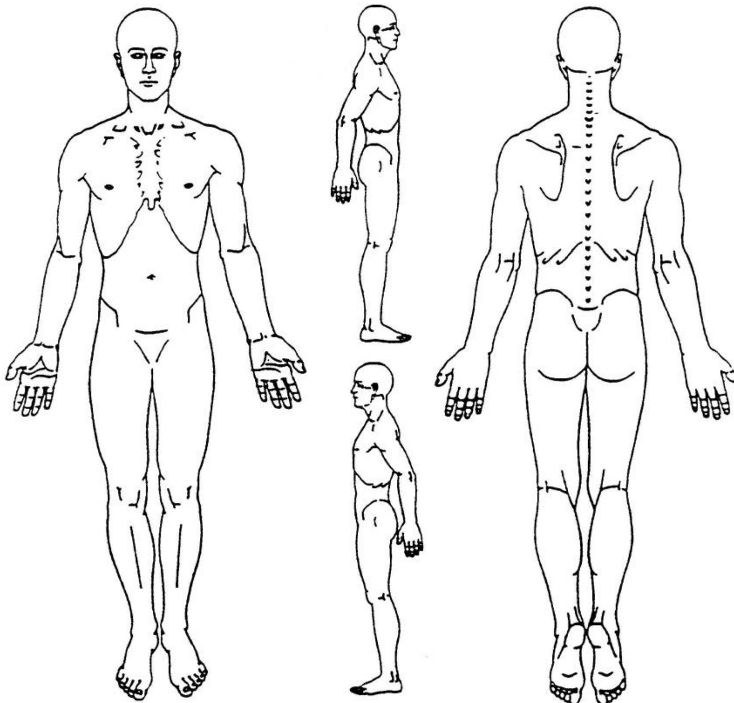
____________________________________________________________

## ADDITIONAL MEDICAL HISTORY

Recent Hospitalization Surgeries/dates:____________________________________________________________

Xrays/MRI: ❑Yes ❑No Results(if known):____________________________________________________________

Current Weight_________(lbs) Current Height__________(inches)



! STABBING * ACHING // BURNING # NUMBNESS/TINGLING

### PAIN or SYMPTOM INTENSITY:

**Please mark your symptoms on the figure accordingly:**

**REQUIRED BY INSURANCE:**

*Rate the intensity of your pain or symptoms from 0 to 10 with "0" denoting none and "10" denoting most severe/intense.*

**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**

**Most painful activity?**____________________________

____________________________________________

**Night pain?** ❑Yes ❑No **Sleep disturbed:_____Hours**

Comments on pain:______________________________

____________________________________________

____________________________________________

What are your goals for physical therapy? ____________________________________________________________

One activity you would love to do that you cannot do now:____________________________________________________________

"*Something unique about me is*":____________________________________________________________

____________________________________________________________

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

Therapist Signature: ____________________________________________ Date:__________________

(By signing, therapist acknowledges reviewing medical history)

**PATIENT SIGNATURE:** ____________________________________________ **Date:** ___________________

(Parent/Guardian if younger than 18 years old)