Confidential Patient Case History

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

Patient's Full Name _____**Nickname**_____ **Birthday** _____
Address:_____ **City** _____ **State**_____ **Zip**_____
Home Phone:_____ **Cell Phone:** _____**Work Phone:**_____ **Ext.**_____
May we leave a voice message if necessary? ☐**Yes** ☐**No** **EMAIL:** _____
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_____
_____
How did you hear about Synergy?_____

MEDICAL HISTORY

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: ❑**Work/School** ❑**Sleep** ❑**Daily Routine** ❑**Other:**_____

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

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:** _____

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**

If yes, please describe: _____

_____

Are you receiving or have you recently received other therapy services? ☐**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 in the section below: _____

_____

_____

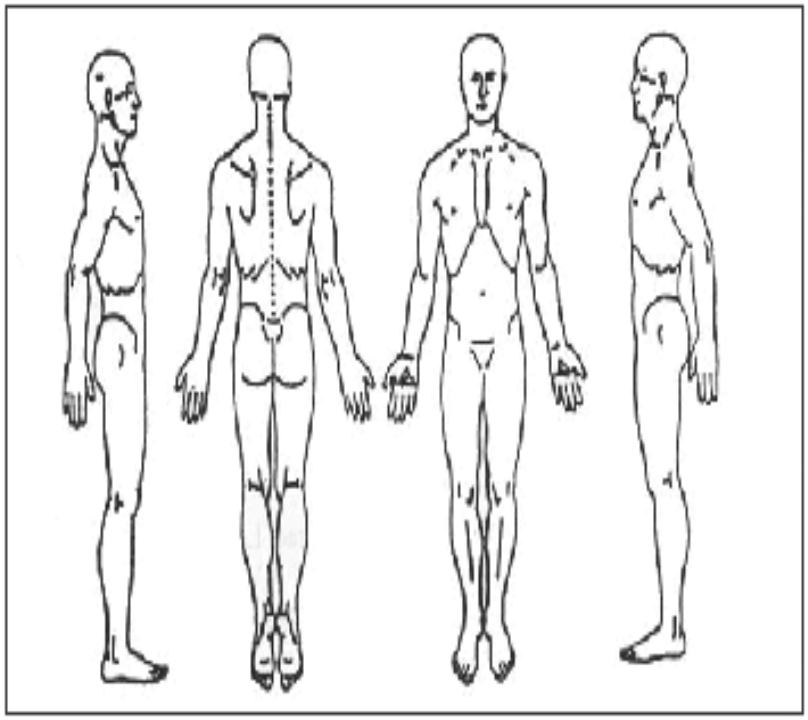
ADDITIONAL MEDICAL HISTORY

Surgeries/dates:_____

Xrays/MRI: ☐Yes ☐No Results(if known):_____

Recent Hospitalization/ Other?_____

Current Weight_____(lbs) Current Height_____(inches)



PAIN INTENSITY:
Please mark your symptoms on the figure accordingly:
! = stabbing ***** = aching **//** = burning **#** = numbness/tingling

Rate the intensity of your pain from 0 to 10 with "0" denoting no pain and "10" denoting most severe pain.

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

Hours sleep disturbed, if yes:_____

What are your goals for physical therapy? _____

_____

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

Females 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)