MSU Health Care

PATIENT HISTORY

Office Use Only
Date PT/OT eval:
MRN:

Legal Patient's Name (First, Middle, Last)

Home Therapy: Are you currently receiving health care services in your home that are billed to your insurance? ☐ Yes ☐ No

Chosen Name:

Pronouns (circle): he/him/his she/her/hers they/them/their

Other Treatment: Have you received any of these treatments this year? ☐ Physical /Occupational / Speech Therapy ☐ Chiropractic/Spinal Manipulation ☐ OMM (Osteopathic Manipulative Medicine)

Work Related Injury: ☐ Yes ☐ No

Auto Related Injury: ☐ Yes ☐ No

EMAIL: *(for exercise program)*:

Reason for Visit (Describe Injury):

Goal (What do you want to do better with therapy?):

Date of Onset:

Onset/Timing: ☐ Number of Prior Episodes: ☐ Gradual Onset ☐ Sudden Onset

How did your pain/problem start? ☐ Unknown ☐ While Lifting ☐ Car Accident ☐ A Fall
☐ Trauma ☐ Overuse ☐ Degenerative Process ☐ Recreation/Sport: ☐ Dental Appt
☐ Other:

Severity of pain/problem: ☐ Improving ☐ Not Changing ☐ Worse
Current Pain: ___/10 **Highest pain in past 2 weeks: ____/10** **Lowest pain in past 2 weeks: ___/10**

Pain is: ☐ Constant ☐ Intermittent ☐ Variable in Intensity ☐ Activity Dependent

Describe your pain/symptoms: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Aching ☐ Periodic ☐ Occasional ☐ Constant ☐ Painful/Stiff when getting out of bed ☐ Other:

Throughout the day, my pain/problem: ☐ Increases ☐ Decreases ☐ Stays the same

Wake up at night when: ☐ lying still ☐ changing positions ☐ lying still and changing positions

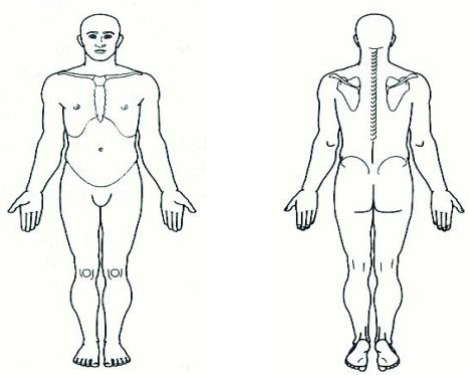
Sleeping Position: ☐ Back, sides and stomach ☐ on right side ☐ on left side ☐ on stomach ☐ on back ☐ chair/recliner

Within the past year, have you had any of the following symptoms? *(check all that apply)*
☐ Unable to control bowel/bladder ☐ Fever/Chills ☐ Numbness of Genitalia ☐ Numbness
☐ Dizziness/Fainting ☐ Unexplained Weakness ☐ Unexplained change in weight ☐ Night Pain/Sweats
☐ Malaise ☐ Vision Problems ☐ Hearing Problems
☐ Other:

Aggravating Factors *(check all that apply):*
☐ Sitting ☐ Going to/raising from sitting ☐ Walking ☐ Up/Down Stairs ☐ Lying Down
☐ Looking Up Overhead ☐ Reach Overhead ☐ Reach In Front ☐ Reach Behind Back ☐ Reach Across Body
☐ Repetitive Activity ☐ Household Activities ☐ Sports/Recreation ☐ Standing ☐ Squatting
☐ Sustained Bending ☐ Cough ☐ Deep Breathing ☐ Sleeping ☐ Talking
☐ Chewing ☐ Swallowing ☐ Yawning ☐ Stress
☐ Other:

Alleviating Factors *(check all that apply):*
☐ Nothing ☐ Medication ☐ Wearing a splint/orthotics
☐ Rest ☐ Cold ☐ Heat ☐ Sitting ☐ Standing
☐ Walking ☐ Lying Down ☐ Stretching ☐ Exercise ☐ Massage
☐ Other:

Please map your areas of discomfort or altered sensation on the body map.
XXX = Pain
000 = Numb/Tingle/Radiating
*** = Weakness



- OVER -

MEDICAL/SURGICAL HISTORY: a. Please check all that apply

☐ ADD	☐ Back Pain	☐ Epilepsy/Seizures	☐ Hypertension	☐ Orthotics
☐ AIDS/HIV	☐ Bleeding Disorder	☐ Falls	☐ Lung Disease	☐ Osteoporosis
☐ Allergies/Hayfever	☐ Brain Injury	☐ Fibromyalgia	☐ Lymphedema	☐ Peripheral Vascular
☐ Ankle Sprains	☐ Cancer	☐ Fracture	☐ Neurological Disorder	☐ Rheumatoid Arthritis
☐ Ankylosing spondylitis	☐ Carpal Tunnel	☐ Head Injury	☐ Neuropathy	☐ Serious Illness/Injury
☐ Anxiety/Depression	☐ Cystic Fibrosis	☐ Headaches	☐ Meniere's Disease	☐ Skin Sensitivities
☐ Arthritis	☐ Developmental Delay	☐ Heart Disease	☐ Muscle/Bone Problem	☐ Stroke
☐ Asthma	☐ Diabetes	☐ Hernia	☐ Neck Injury	☐ Urinary Problems
☐ Surgery History: *(please list & include dates (mo/year):*			☐ Obesity	☐ Vertigo

MEDICATIONS: Do you take prescription or nonprescription medication? ☐ YES, ☐ NO If yes, please list below or attach a list.

Prescription	Non-prescription

ALLERGIES: Do you have any allergies? ☐ None ☐ Bees ☐ Latex ☐ Perfumes/lotions ☐ Coconut ☐ pine/linden ☐ Adhesive/tapes ☐ Other *(please specify):*

(We use various emollients and tapes, please feel free discuss ingredients with therapists.)

SOCIAL HISTORY:

Smoking Status: ☐ Never ☐ Former ☐ Current Everyday ☐ Current Some Day ☐ Smoker – Status Unknown

Employment/Work (job/school)	☐ Full time	☐ Part time	☐ Retired	☐ Student	☐ Unemployed	☐ Disability

Occupation:	Sports/Hobbies:

Exercise Level: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy
(Please include type of exercise, days/wk, and average # minutes)

Marital Status: ☐ Unknown ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic Partner	# of Children:

Living Status: ☐ Alone ☐ Live with others	Pet(s): *(please specify)*

Single/Multi-level home/work: ☐ Single-level home ☐ Multi-level home ☐ Single-level work ☐ Multi-level work

Able to care for self: ☐ Yes ☐ No *(if no, who cares for you?)*

Patient signature: **Date:**

Therapist Signature: **Date:**