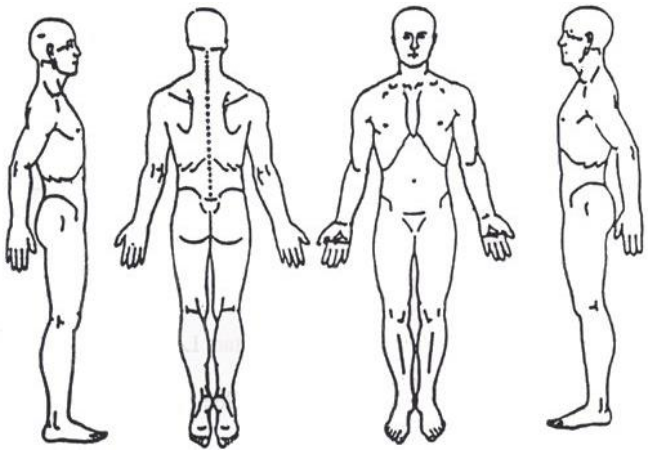
Integrative Physiotherapy

**Physical Therapy & Sports Medicine**

## MEDICAL HISTORY

**Instructions**- On the body, please indicate where your symptoms are located at the present time by using the symbols below that represent the pain type.

**OOO**- Pins/Needles **XXX**- Burning **ZZZ**- Deep Ache **///**- Sharp/Stabbing



**Please rate your pain on a scale of 0 (no pain) to 10 (paralyzing pain)**

On a good day:_____/10 On a typical day:_____/10 On a bad day:_____/10

**Date of Onset**_____ **How did symptoms begin?** (a fall? sports injury?)_____

**Symptoms**_____

*Symptom Aggravators*_____

*Symptom Alleviators*_____

**Related Surgeries?** (Please specify type and month/year):_____

**Other treatment you have sought for these symptoms and their outcomes**

| | | | | |
|---|---|---|---|---|
| ☐ *Chiropractor* | short term relief | minor relief | no relief | other_____ |
| ☐ *Massage Therapy* | short term relief | minor relief | no relief | other_____ |
| ☐ *Physical Therapy* | short term relief | minor relief | no relief | other_____ |
| ☐ *Cortisone Injection* | short term relief | minor relief | no relief | other_____ |

**Please check any of the following conditions you currently have or have had in the past**

| | | | |
|---|---|---|---|
| □ High blood pressure | □ COPD | □ Arthritis | □ Stroke |
| □ Irregular heartbeat | □ Epilepsy | □ Osteoporosis | □ Chronic Fatigue |
| □ Pace maker | □ Tuberculosis | □ AIDS/HIV | □ Scoliosis |
| □ Heart Disease | □ Diabetes | □ Hepatitis | □ Headaches |
| □ Other blood borne infection/disease | | | |

**Please list medications you are currently taking**_____

**What are your goals for physical therapy?**_____

*Patient Signature:*_____ *Date:*_____