KINETIC EDGE PHYSICAL THERAPY

Medical History

Date:		Name:		Age:	
Height:		Weight:		BMI:	

ABOUT YOUR CURRENT COMPLAINT:

1. What is the complaint that brought you here? _____

2. What caused this complaint? _____

3. When did this complaint begin or recently become worse? Approximate Date: _____

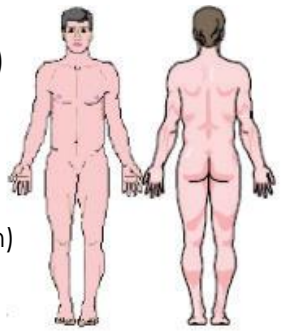
4. What are your chief complaints (check all the boxes that apply)

☐ Awakened by pain ☐ Difficulty finding a comfortable position ☐ Loss of Motion ☐ Swelling ☐ Other: _____

☐ Difficulty falling asleep ☐ Loss of Function ☐ Pain ☐ Weakness

5. How often do you experience your symptoms? (check the box that applies)

☐ Constantly (76%-100%) ☐ Frequently (51%-75%) ☐ Occasionally (26%-50%) ☐ Intermittently (0%-25%)



6. How would you rate your ability to perform daily activities? (circle the percentage that applies)

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Unable No Problem

7. In general, would you say your general health is… (check the box that applies)

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

8. Rate your symptom intensity in the past 5 days (circle the number for your **BEST** and **WORST** pain)

0 1 2 3 4 5 6 7 8 9 10

None Emergency Room

9. What is your work status? (check the box that applies)

☐ Full Time	☐ Light Duty	☐ Not Working	☐ Retired	☐ Job Title: _____
☐ Part Time	☐ Modified Duty	☐ Homemaker	☐ Student	

10. Have you had any surgeries for this condition? ☐ Yes ☐ No Date of surgery: _____ Type: _____

11. What tests have you had for this complaint? (check all the boxes that apply)

☐ None ☐ X-Ray ☐ CT Scan ☐ MRI ☐ Bone Density Scan ☐ Ultrasound ☐ Results of Test: _____

12. Is this **complaint work related**? ☐ Yes ☐ No Last Date Worked: _____ Occupation: _____

13. Is this complaint auto related? ☐ Yes ☐ No

14. Is this injury in litigation with an attorney? ☐ Yes ☐ No Name of Attorney: _____

15. Have you seen any other medical provider for this specific condition or injury? _____

ABOUT YOUR GENERAL HEALTH:

1. Please check all the boxes for the medical conditions that you **have currently** or **had in the past**:

☐ Cancer	☐ Joint Replacements	☐ Headaches	☐ Osteoporosis
☐ Diabetes	☐ Metal Implants	☐ Pacemaker	☐ Epilepsy
☐ Heart Condition	☐ Syncope/Fainting	☐ Asthma	☐ Shortness of Breath
☐ High Blood Pressure	☐ Osteoarthritis	☐ Allergies	☐ Malaise/Fatigue
☐ Nausea/Vomiting	☐ Bowel Dysfunction	☐ Dizziness	☐ Tobacco/Nicotine (Use)
☐ Rheumatoid Arthritis	☐ Weight Change	☐ Pregnant	☐ High Cholesterol
☐ Depression/Anxiety	☐ Other: _____		

2. Please list other surgeries: _____

3. Please list allergies: _____

4. Please list any medications you are taking: _____

ADDITIONAL INFORMATION

What are your goals with PT/OT treatment? _____

Patient Signature: _____ Date: _____

KINETIC EDGE
PHYSICAL THERAPY

*****For office use only:**

Name: _____ **Date:** _____ **DOI/DOS:** _____

Region: _____ **Frequency/ Duration:** ____X____ **Work Status:** F L O M

Affected Side: ____ Right ____ Left ____ Dominant ____ Non-Dom

Diagnosis codes: _____ _____ _____ _____ _____

Surgical Status: ____ Surgical ____ Non-Surgical ____ Pre-Surgical

Reasons for therapy:

____ Atrophy ____ Muscle Weakness ____ Pain ____ Stiffness ____ Swelling/Edema ____Gait ____ Coordination

COMORBIDITIES:

____ None ____ Maladaptive Pain Response ____Multiple Treatment Areas

GOALS:

____ HEP
____ Able to run
____ Return to sports/fitness
____ Improve core strength
____ Improve UE strength
____ Improve LE strength
____ Work full duty without restriction
____ Improve UE ROM
____ Improve LE ROM
____ Improve L ROM
____ Normalize L-S ROM
____ Return to prev level of function
____ Pain Goals
____ Improve Cervical ROM
____ Improve Shld strength
____ Improve Shld ROM
____ Decrease HA's

____ _____

____ _____

____ _____

_____

PLAN:

____ Ther Act ____ Patient Ed ____ Ther Ex ____ Manual Therapy ____ Modalities PRN ____ Neuro Re-ed ____ Gait Trng

Interested in Medical Fitness? ☐ Yes ☐ No

Provider Notes: