SPINE& SPORT
PHYSICAL THERAPY

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PATIENT HISTORY

NAME____ DATE______________________

1. What is your problem or injury?____

2. How did your problem or injury begin? ____

3. Is your injury work related or the result of a motorvehicle accident? ☐Yes ☐No
   Date of Injury:________________

4. How long ago did your injury begin? ____

5. What is your type of work?____

6. Are you currently working? ☐Yes ☐No
   If no, is it because of your injury? ☐Yes ☐No

7. Before this injury, were you completely free of symptoms? ☐Yes ☐No

8. Have you ever had a similar injury before? ☐Yes ☐No

9. What, if any, treatments have you had for your current injury?
   ☐Physical Therapy ☐Chiropractics ☐Medical ☐Other ______________________________

10. What eases your pain?
    ☐Sitting ☐Standing ☐Walking ☐Lying Down ☐N/A

11. What makes your pain worse?
    ☐Sitting ☐Standing ☐Walking/Running ☐Lying Down ☐Reaching/Lifting Over Head ☐N/A

12. Do you have any feelings of pins and needles or numbness?
    ☐Yes ☐No ☐Other__________________________

13. Do you have any other problems? ☐Yes ☐No

14. Show your area of pain or discomfort on the figure of the body below.