Limp In, Leap Out

Mid-Michigan Physical Therapy Specialists

Limp In, Leap Out

Formerly: Fowlerville PT Specialists

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Patient Report Form

Please complete the following questions. Your answers will enable us to gain a better understanding of your complaints and subsequently help to establish a successful treatment plan for you.

1. What is the reason, that your Doctor has referred you for physical therapy? _____
2. How long ago did this problem start? OR get noticeably worse? _____
3. How did the problem occur? _____
4. Have you undergone any diagnostic tests to evaluate your complaints? _____
5. Have you had any other treatment for your current complaints, to date? _____
6. Have you ever had this problem in the past? _____
7. Aside from Physical Therapy, has your Doctor recommended any other treatment for your current complaints? _____
8. Please list out the medications, that you are currently taking, for this and other conditions:
9. Have you ever attended for Physical Therapy in the past? Yes ( ) No ( )
10. Are you currently working? Yes ( ) No ( )
    Would you describe your work as being: Strenuous ( ) Moderately strenuous ( )
    Mildly strenuous ( ) Sedentary ( )
    Do you spend most of your day: Sitting ( ) Standing ( ) Walking ( )

Pain Profile

11. Where did your pain start?

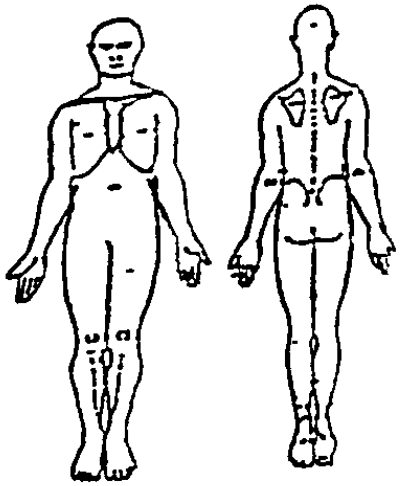
12. Has it spread to any other area?

13. Where is the pain now (last 48hours)?

14. Do you have any numbness or tingling?

15. Is the pain constant, almost constant, intermittent? Or depend on your activities?

16. If 0 is no pain and 10 is screaming pain, how would you rate the severity of your pain: /10



17. What makes the pain worse?

18. What makes the pain better?

19. Is your sleep disturbed, due to pain?

20. How does your pain vary throughout the day?

Other Symptoms

21. Do you have any of the following complaints?

Headaches	_____	Stiffness	_____
Dizziness	_____	Swelling	_____
Muscle weakness	_____	Joint locking/giving way	_____
Bladder or bowel problems	_____	Balance/ coordination problems	_____

22. As a result of your current complaints, what activities are you unable to perform, have difficulty performing or you are avoiding, so as not to aggravate your condition? Please try to quantify these limitations:
    a. _____
    b. _____
    c. _____
    d. _____

Past Medical History

23. Have you had or are you having any of the following medical conditions or problems?

Heart problems	_____	Respiratory problems	_____
Diabetes	_____	Cancer	_____
Thyroid problems	_____	Arthritis	_____
Fractures	_____	Bone /Joint Surgery	_____
Surgery	_____	Epilepsy	_____
Stroke	_____	Osteoporosis	_____
Grief	_____	Stress	_____
Depression	_____	Other	_____
Abrupt weight change	_____		
High Blood pressure	_____		

24. Are you pregnant? Yes ( ) No ( ) N/A ( )

25. What are your expectations in attending for Physical Therapy? _____
_____
_____

26. Is there anything else regarding your current condition or your past medical history that you think we should know? _____
_____

_____ _____
Patient Signature Date

Thank you for completing this report

( ) The information in this report, has been reviewed with the patient.
( ) Other: _____

_____ _____
Physical Therapist's Signature Date