AXIS PHYSICAL THERAPY PATIENT HISTORY

NAME _____ Age _____

OCCUPATION_____ HOBBIES/SPORTS _____

DESCRIPTION OF PRESENT INJURY, ACCIDENT, ILLNESS OR CONDITION: _____

_____

_____

_____

ONSET DATE _____ PLEASE CIRCLE: SUDDEN/GRADUAL ONSET

AT THE **PRESENT TIME** I AM ABLE TO WORK:

_____ without restrictions
_____ with restrictions
_____ unable to work due to dysfunction
_____homemaker
_____retired
_____ other

HAVE YOU HAD **ANY PHYSICAL THERAPY** DURING THE CURRENT CALENDAR YEAR? YES/NO FOR THE SAME CONDITION? YES/NO
IF YES, WHERE AND WHEN?_____

LIST **ALL** PRESCRIPTION MEDICATION YOU ARE TAKING _____

_____

_____

PLEASE LIST ANY SURGERIES/CONDITIONS FOR WHICH YOU HAVE BEEN HOSPITALIZED:

DATE	REASON
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HAVE YOU EVER HAD:

_____High Blood Pressure _____Epilepsy/Seizures _____Arthritis
_____Heart Disorders _____Lung Disorders _____Pacemaker
_____Stroke _____Hearing Loss _____Osteoporosis
_____Heart Disease _____Cancer _____ Allergies to tape/lotion
_____Circulation Disorders _____Metal Implants _____ Are you pregnant?
_____Emotional/Psychological Problems _____Diabetes _____ Use Tobacco?

PLEASE LIST ALL RECENT DIAGNOSTIC STUDIES (MRI, X-RAY, CT-SCAN etc.)

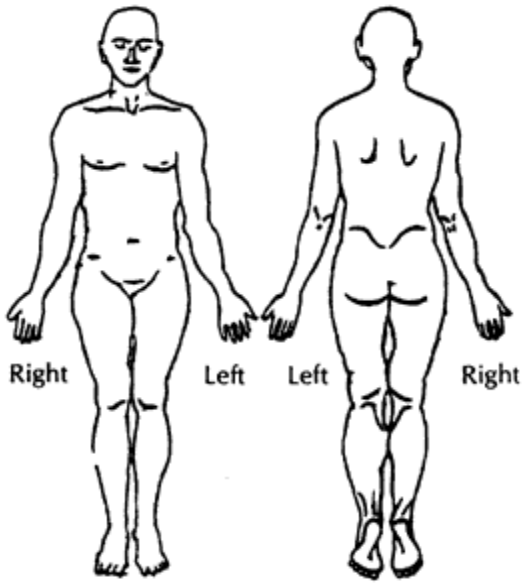
_____

RATE YOUR AVERAGE DISCOMFORT ON THE SCALE BELOW

0_____1_____2_____3____4_____ 5_____6_____7_____8_____9_____10
(no pain) (moderate pain) (severe pain)

HAS THE PAIN BEEN: CONSTANT/INTERMITTENT?
IMPROVING/NOT CHANGING/GETTING WORSE

PLEASE INDICATE THE AREAS OF DISCOMFORT OR ALTERED SENSATION
USE THE APPROPRIATE LETTER(S)



N=Numbness B=Burning
S=Stabbing A=Aching
P=Pins and Needles

Form reviewed by therapist:_____(PT initials) _____Date