



1 Anderson Rd, Suite 104 Bernardsville, N.J 07924
Phone: 908-696-8900 Fax: 908-696-8902

Patient History / Problem List

Patient Name: _____

Date: _____

Date of Birth: ____ / ____ / ____

Physician: _____

Initial Eval: _____

Date of Next .Physician Visit? ____ / ____ / ____

A. Personal Medical History

1. Please Circle all conditions which you have or have had in the past:

- | | |
|----------------------------|---------------------------|
| Allergies | High blood pressure |
| Angina/chest pain | HIV positive |
| Arthritis | Hypoglycemia |
| Asthma/breathing disorders | Kidney disease |
| Back pain | Liver/gallbladder disease |
| Blood disorders | Lyme disease |
| Bowel/bladder disorder | Meningitis |
| Cancer _____ | Multiple Sclerosis |
| Diabetes | Neuritis |
| Dizziness/fainting | Osteoporosis |
| Eating disorders | Pacemaker |
| Epilepsy/seizures | Parkinson's Disease |
| Fractures | Phlebitis |
| Head aches | Pregnant |
| Hearing difficulty | Ringing in ears |
| Heart conditions/disease | Stroke |
| Hepatitis | Tuberculosis |
| Hernia | Other _____ |

2. Allergies (specify): _____

3. Medications: _____

4. Implants(metal/plastic): _____

5. Diagnostic tests/procedures: _____

6. Surgeries: _____

Pt. Name: _____

Birthdate: _____

B. Medical History

1. Date of injury/ start of symptoms: ____/____/____

2. Have you ever had these symptoms before? Y / N

3. Do you currently have pain? Y / N

4. How would you rate your pain?

(0 = no pain 5 = moderate pain 10 = severe pain)

At Best: 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10

At Worst: 0-1- 2 - 3 - 4- 5 -6-7 -8 - 9 -10

5. Does anything make your pain better? _____

6. Does anything make your pain worse? _____

7. Please indicate where your symptoms are located. _____

8. Circle which apply to your symptoms:

work related recurrence of previous injury
related to fall motor vehicle accident
athletic/recreational related to lifting
daily activities other: _____

9. Have you had a related surgery? Y / N

10. Are you presently employed/working? Y / N

11. Do you plan on returning to work? Y / N

12. What was your level of daily activity prior to current symptoms/injury?

independent required assistance dependent

13. What are your current problems and goals for therapy?

Signature

Relationship to patient

Date

