Tonic Physical Therapy

Comprehensive History Form

Patient Name:
Date of Birth/Age:
Date:

Past history of similar symptoms:

History of present episode/duration of symptoms:

Findings of any test procedures:

Previous surgeries and/or traumas :

Patient Name:
Date:

Medications presently being taken:

General health or medical problems which may be related to problem:

Any movements/activities that increase your pain?

When and what do you think caused your pain? Why?

Since it's initiation, has the pain changed?

Are your symptoms presently becoming worse, better, or staying the same?

Name:
Date:

What eases your symptoms?

Do you gain relief with medications and how has your dosage changed?

Have you experienced any dizziness, blurred vision, nausea, bilateral numbness or tingling sensation? List dates, location and activity.

In what position do you sleep? Do you use pillows or supports?

What are your goals for physical therapy?

Name:
Date:

List important leisure, recreational activities, and social history:

Have you had previous experience with physical therapy in the past and or other treatments and how did your body respond? Please list date/duration of treatment.

How much time do you have to fit exercise into your daily routine?

Are you currently under the care of a physician, psychiatrist, or other health care professional other than the one who prescribed your physical therapy?