ATLANTIC PHYSICAL THERAPY®

Patient Background Information

Name: _____ **Date:** _____
Physician: _____

Past Medical History: Please check if you have (or have had) any of the following:

___Heart Problems	___ Rheumatoid Arthritis	___ Emphysema
___ High Blood Pressure	___ Osteoarthritis	___ Asthma
___ Diabetes	___ HIV/AIDS	___ Cancer
___ Seizures	___Stomach Problems/Ulcers	___ Other: _____

Medications: Please list any medications that you take regularly, and the physician who prescribed them: _____
_____
_____

Allergies: Please list any allergies that you have and describe your reaction: _____
_____

Current Medical History:
What is the primary reason for your visit today? _____
When did the injury/condition first occur? _____
Please describe how the injury/condition occurred: _____
_____
What makes symptoms worse? _____
What relieves your symptoms? _____
If you have pain, and then make an "X" on the scale below to indicate how much you have at rest/low activity, and then make an "O" on the scale to indicate how much you have during an episode/high activity:

_____

No Pain **Worst Pain Ever**

What is your occupation? _____
Please describe a few things which you are unable to do since this injury/condition occurred which you normally can do? _____
Please describe any other concerns or information which you would like to discuss with you physical therapist? _____
_____
_____