OrthoFlex Physical Therapy & Rehabilitation Medical History

Name: ______________________________ Age: __________ DOB: ______

Describe your current complaint: ______________________________

Hand dominance: Right Left Occupation: ______________________________

When did your condition begin? ______________________________
How did your problem begin? ______________________________

Have you been treated for the same problem in the past? YES NO
Have you had other treatment for this current condition? YES NO
Have you had surgery? YES NO

If yes to any of the above, please describe: ______________________________
____

What is your current level of pain? (0-NO pain, 10 – emergency room care required)

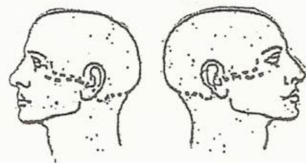
At rest: 0 1 2 3 4 5 6 7 8 9 10 With movement: 0 1 2 3 4 5 6 7 8 9 10

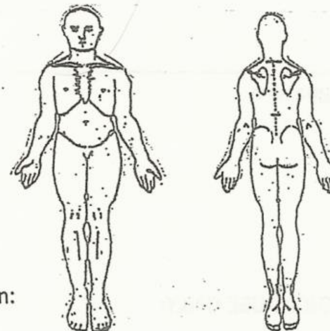
Please choose one:
Since your condition began your symptoms have: **INCREASED** **DECREASED** **NOT CHANGED**

What makes your problem better? ______________________________
What makes your problem worse? ______________________________

What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%

Please mark on the drawings where you feel your pain:





Please **circle** any of the following services that you have received for this condition:

Orthopedist
Physical Therapy
X-Rays
NCV
Chiropractor
Occupational Therapy
CT Scan
Injection(s)
Neurologist
Massage Therapy
MRI
Cast or Brace
General Practitioner
Myelogram
EMG
Other: ______________________________
Emergency Room