

**Orthopedic and Fracture Clinic**

Physical Therapy  
Patient Medical Profile

**Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

Dear Patient: Your referring physician may benefit financially by you receiving physical therapy services at this facility. You are not obligated to receive therapy at this facility. If you have any questions or concerns regarding this, please ask your treating therapist.

Please provide us with this important health information. If you do not understand any portion your therapist will assist you during the evaluation.

Reason for therapy? \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

What caused your condition? \_\_\_\_\_

Describe surgical /medical procedures related to present condition \_\_\_\_\_

\_\_\_\_\_ Surgical Date: \_\_\_\_\_

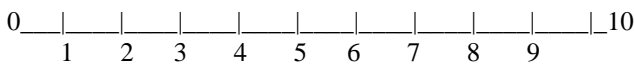
**Diagnostic Tests:**     X-Ray     MRI     CT Scan     Other: \_\_\_\_\_

Results: \_\_\_\_\_

**Prior Treatment for this or similar condition:**    None     Medical Doctor     Chiropractor     Exercise  
 Medication     Medication     Physical Therapy     Occupational Therapy     Speech Therapy  
 Injections     Massage     Acupuncture     Other \_\_\_\_\_

**Please complete this section describing your symptoms.**

Rate your average pain or symptom on a scale of 0-10 with "0" equals no pain and "10" equals the worst pain imaginable. Mark line at the point that represents your pain or symptom.



**Pain Description:**

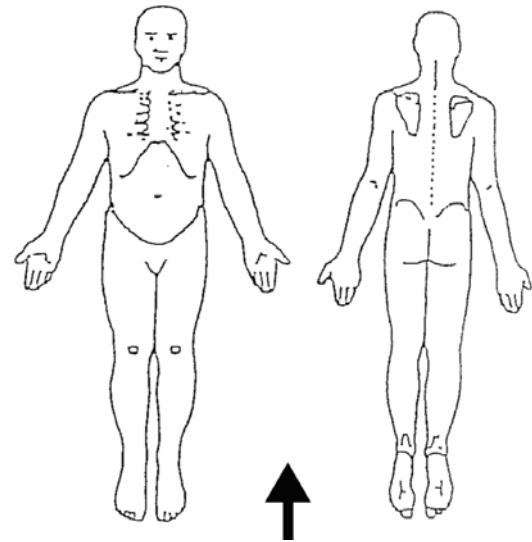
- Throbbing     Pain only with movement     Swelling
- Dull Ache     Numbness     Constant
- Burning     Tingling     Intermittent
- Sharp     Radiating     Frequent
- Sharp with movement

**Time of Day Symptoms are worse:**

- Upon awakening     PM     Sleep Disturbed
- AM     Late Night     Same all the time
- Midday     Varies

**Symptoms are:**

- Improving     The Same     Worsening



Please mark the area(s) of pain or symptom on above diagram

**Symptoms increase with:**

- Activity     Lie     Sit     Turn head left     Fatigue     Other \_\_\_\_\_
- Bend     Reach     Stand     Turn head right     Walk    \_\_\_\_\_
- Grasp     Rest     Transition     Cough/Sneeze     Stairs    \_\_\_\_\_

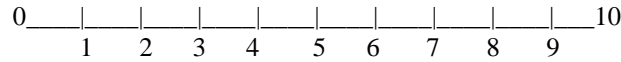
**Symptoms are better with:**

- Walk     Heat     Medication     Positioning     Sitting     No Relief     Other \_\_\_\_\_
- Exercise     Elevation     Ice     Rest     Stairs     Massage    \_\_\_\_\_

**You are Experiencing:**

- Balance Difficulty     Gait (Walking Difficulty)     Nausea     Weakness     Dizziness
- None of these

Rate how near you are to your normal function on a scale of 0-10 with "0" equals not performing your normal activities at all and "10" equals doing all your normal activities without difficulty. Mark the line at the appropriate point.



**Which activities are limited?**

- Personal Care
- Home making
- Work activities
- Exercise
- Driving
- Child Care
- Recreation
- Community Activities

**Which of the following over the counter medications are you taking or have you taken this last week?**

- Ibuprofen (Advil)
- Antihistamines
- Decongestants
- Naturopathic
- Vitamins
- Antacids
- Aspirin
- Laxatives
- Acetaminophen (Tylenol)

**Which of the following prescription medications are you taking?**

- Allergy
- Reflux
- Blood pressure
- Other: \_\_\_\_\_
- Heart
- Anti-Inflammatory
- Muscle relaxants
- Pain
- Depression
- Anti-nausea/dizziness
- Antibiotic
- Respiratory
- Hormones
- Seizure

**Medical History: Have you been diagnosed with or experienced any of the following:**

- Allergy
- Amputation
- Balance Problems
- Bowel/Bladder Problems
- Cancer
- Cardiac condition
- Chemical Dependency
- Diabetes
- Dizziness
- DVT
- Fibromyalgia
- Fractures
- Gastrointestinal
- Headaches/Migraines
- Hearing loss
- Hypertension (High blood pressure)
- Labor/Delivery Complications
- Neurological condition
- Osteoarthritis
- Osteoporosis
- Psychological condition
- Respiratory condition
- Rheumatoid Arthritis
- Seizures
- Sleep disturbances
- Thyroid
- TMJ
- Vision

Other: \_\_\_\_\_

**Work History:**

Occupation: \_\_\_\_\_

**Demands of Job:**

- Lift
- Grip
- Carry
- Computer
- Drive
- Push
- Prolonged standing
- Prolonged sitting
- Phone
- Pull
- Overhead work
- Supervisor

**Current Status:**

- Full Duty
- Light Duty
- Temporary Disability
- Permanent Disability
- Applied for Disability
- Modified duty/job

Restrictions: \_\_\_\_\_

Anticipated return to work date or work status change: \_\_\_\_\_

**How do you learn best:**

- Listening
- Reading
- Observation
- Demonstration of task
- Performance

What activity are you unable to do currently that you would like to return to after therapy?

\_\_\_\_\_

**Physician Follow-up:**

- Plan to schedule physician recheck after therapy series is complete if needed.
- Physician recheck is scheduled for this date: \_\_\_\_\_.
- Other: \_\_\_\_\_