Staszak Physical Therapy And Wellness Center
Patient History

488 E 11th Ave. Suite 150a• Eugene, Oregon 97401
tel: 541.505.8180 • fax: 541.505.7134
staszakpt.com

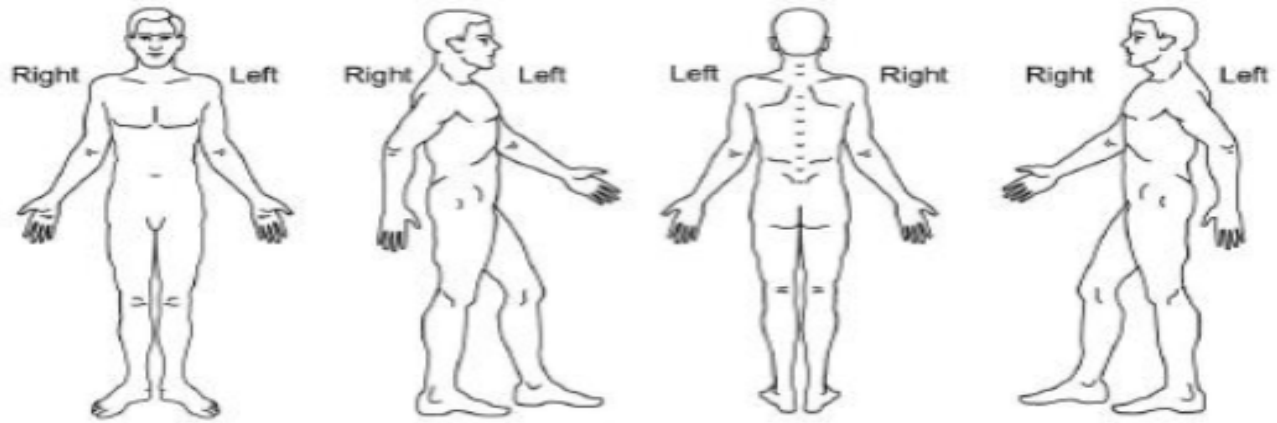
To assist your therapist with the evaluation, please fill out the form below. If you do not understand a question, your therapist will assist you. Thank you for your time.

Today's Date: _____ Name:_____ Date of Birth: _____
Next Doctor's Appointment: _____ Employer and Occupation: _____
Presently working? Select One If no, last day worked? _____
Right handed ☐ Left handed ☐
What type of problem brings you to the clinic? _____
Injured how? _____ Date of onset: _____
Previous treatment for this condition: _____
Current treatments for current or prior conditions: physical therapy, chiropractic, massage, other: _____
_____
What are your goals for therapy? _____
Pain Assessment: Describe your pain today: _____
_____
Pain pattern: ☐ Constant ☐ Intermittent Pain quality: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

Place a vertical mark on the line below to indicate your least, average and worst pain scores:

0 1 2 3 4 5 6 7 8 9 10
No Pain **Worst Possible Pain**

Shade in the figures below to indicate where your pain is located.



Top 3 Limitations:

Activity	**Rating 0 (Unable) to 10 (No Difficulty)**
1._____	
2._____	
3._____	

Stratford, P., Gill, C., Westaway, M., & Binkley, J. (1995). Assessing disability and change on individual patients: a report of a patient specific measure. Physiotherapy Canada, 47, 258-263.

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LIST OVER-THE-COUNTER and PRESCRIBED medications you are currently using (including pills, injections, and/or skin patches) - please attach or provide list: _____

_____

_____

Have you **EVER** been diagnosed as having any of the following conditions?

Cancer	YES	NO	If **YES**, describe what kind: _____								
Heart problems	YES	NO	Asthma	YES	NO	Fibromyalgia	YES	NO			
Pacemaker	YES	NO	Tuberculosis	YES	NO	Thyroid problems	YES	NO			
High blood pressure	YES	NO	Emphysema/Bronchitis	YES	NO	Hearing loss	YES	NO			
Stroke	YES	NO	Kidney disease	YES	NO	Headaches/Migraines	YES	NO			
Neurological disorder	YES	NO	Hepatitis	YES	NO	Epilepsy	YES	NO			
Rheumatoid Arthritis	YES	NO	Diabetes	YES	NO	History of MRSA	YES	NO			
Other arthritic conditions	YES	NO	Anemia	YES	NO	History of Clostridium	YES	NO			
Osteoporosis	YES	NO	Depression	YES	NO	difficile (C-diff)					

Other: _____

Allergies: _____

Previous Diagnostic Tests: ☐ X-ray ☐ Ultrasound ☐ MRI ☐ CT scan ☐ bone scan ☐ Other: _____

List any relevant surgery or injury that you have had:

Date	Injury/Surgery	How was it treated

Do you use:	Tobacco	YES	NO	Caffeine (soda/coffee)	YES	NO
Recently noticed:	Weight loss/gain	YES	NO	Fatigue	YES	NO
	Nausea/Vomiting	YES	NO	Weakness	YES	NO

How do you best learn? Pictures Reading Listening Demonstration Other

_____

_____

_____

Therapist's signature Date Time