Physical Rehabilitation Services

Ross Township
1033 Perry Highway
Pittsburgh, PA 15237
(412) 366-3880

Franklin Park
2400 Corporate Dr #201
Wexford, PA 15090
(724) 940-3990

Physical Rehabilitation Services – Medical Health History

Name _____ Age _____ Occupation_____

For this problem/condition

Check which applies to your symptoms:

□ Work related injury □ Athletic/Recreational injury □ Cause unknown

□ Auto accident related injury □ Injury related to lifting □ Injury related to falling

□ Recurrence of previous injury

□ Other_____

Have you had these symptoms before? □ Yes □ No

Are your symptoms? □ Getting worse □ The same □ Improving

Have you had? □ X-ray □ MRI □ Other scan
If so, approximate date _____
□ Surgery
If so, approximate date _____

Been treated by? □ Physical Therapist □ Occupational Therapist □ Chiropractor

Do you currently have problems with the following? □ Standing □ Walking
□ Up from chair □ Overhead activities □ Lifting □ Bending
□ Driving

Is your sleep at night affected? □ Yes □ No If yes, explain_____
_____

List any allergies _____

Do you smoke? ☐ Yes ☐ No _____ Packs/Day **Smoked in the past?** ☐ Yes ☐ No **How many years?** _____

Do you drink alcohol? ☐ Yes ☐ No _____ Drinks/Week

List medications you are presently taking (or provide list) _____
_____
_____

List major surgery and hospitalizations _____
_____
_____

Are you currently being seen by a Home Health Agency? ☐ Yes ☐ No Agency Name _____

Does anyone (other than family) come to your home to assist you? ☐ Yes □ No

Have you had PT, OT, Speech or been treated by a Chiropractor in this calendar year? ☐ Yes □ No

Physical Rehabilitation Services – Medical Health History – continued

Do you have or have history of the following?

	Yes	No
Diabetes	☐	☐
Heart Disease	☐	☐
Chest Pain/Angina	☐	☐
High Blood Pressure	☐	☐
Stroke	☐	☐
Cancer	☐	☐
Osteoporosis	☐	☐
Rheumatoid Arthritis	☐	☐

Do you have a history of the following?

	Yes	No		Yes	No
Heart Attack	☐	☐	Osteoarthritis	☐	☐
Pacemaker	☐	☐	Gout	☐	☐
Circulatory Disorder	☐	☐	Fracture	☐	☐
Phlebitis/DVT	☐	☐	Metal Implant	☐	☐
Asthma	☐	☐	HIV/AIDS	☐	☐
Lung Disease	☐	☐	Depression	☐	☐

Have you experienced in the past 3 months?

	Yes	No		Yes	No
A change in your health	☐	☐	Change in vision/hearing	☐	☐
Shortness of breath	☐	☐	Upper respiratory infection	☐	☐
Chest pain/pressure	☐	☐	Urinary tract infection	☐	☐
Swollen ankles	☐	☐	Unusual skin discoloration	☐	☐
Calf pain with exercise	☐	☐	Wound that does not heal	☐	☐
Headaches	☐	☐	Loss of strength/energy	☐	☐
Dizziness	☐	☐	Change in appetite	☐	☐
Falls or near falls	☐	☐	Unexplained weight change	☐	☐
Tingling/Numbness	☐	☐	Change in bowel or bladder function	☐	☐
Fever/chills/sweats	☐	☐	Menstrual Irregularities	☐	☐
Nausea/vomiting	☐	☐	Pregnancy	☐	☐
Difficulty swallowing	☐	☐	Urinary leakage with exercise/ coughing/or sudden urge	☐	☐
Constant pain unchanged by rest Or movement	☐	☐			

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian/Representative Date

Therapist Use Only

BP_____ Pulse_____ %SpO2_____ Height_____ Weight_____
BMI _____

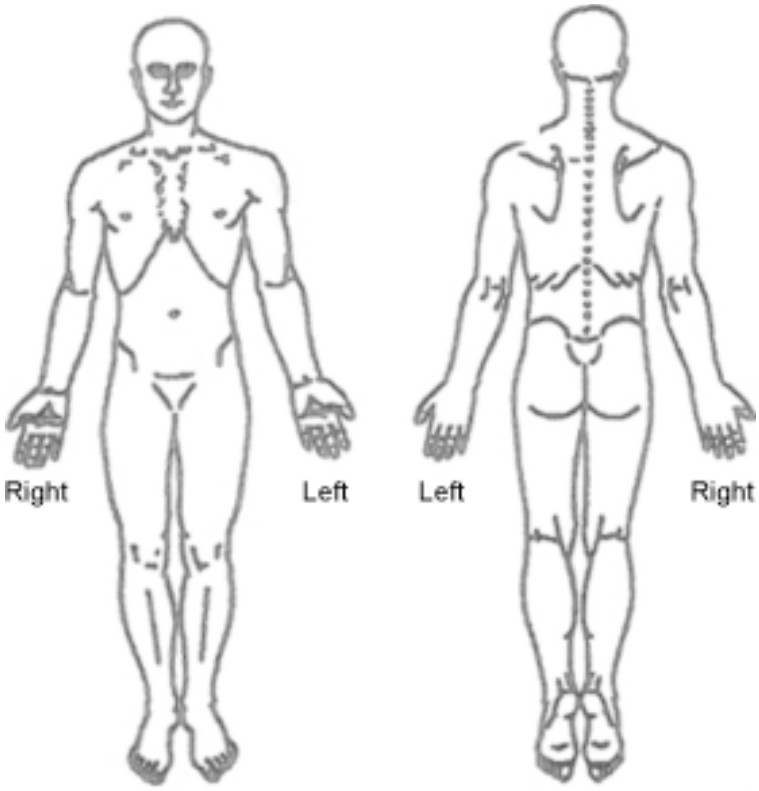
_____ _____
Signature of Therapist Date

Pain and Symptom Status Report

Name _____ Date _____

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing.

Ache	Burning	Numbness
MMMM MM	– – – – –	OOOO OOO
Pins & Needles	**Stabbing**	**Other**
□□□□□□□□ □□□□□□	/ / / / / / / / / / / / /	x x x x x x x



Chief Complaint and Visual Analog Scale

My Chief Complaint is: _____

Date First Symptom of Your Problem Occurred on: _____

2nd Complaint: _____

3rd Complaint: _____

Please circle on the scale below to indicate your CURRENT level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your AVERAGE level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**
Please circle on the scale below to indicate your WORST level of pain:												
No Pain	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**Pain as bad as it gets**

Additional Comments: _____

_____