FOLSOM PHYSICAL THERAPY
and Training Center

(916) 355-8500
115 Natoma Street
Folsom, CA 95630
fpt@folsomphysicaltherapy.com

HISTORY CURRENT ISSUE

Patient Name:

1. Describe the current problem that brought you here.

2. When did your problem first begin?

Weeks ago

Months ago

Years ago

3. Since that time, is it:

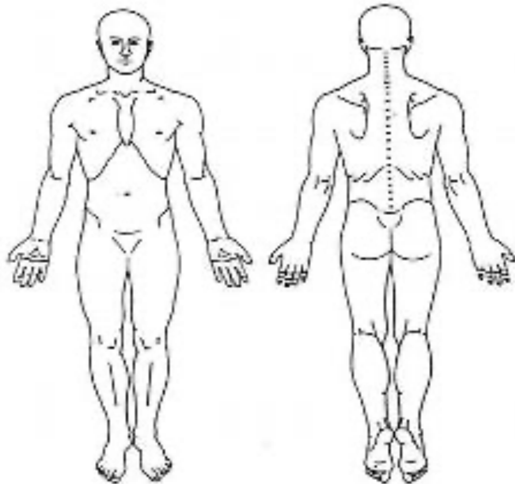
Staying the same

Getting worse

Getting better

4. Why or how might the problem occur?

5. Circle where your symptoms are located on the figure below after you printed out the form.



6. Describe the nature of your symptoms (i.e. tingling, burning, numbness, weakness).

7. On a scale of 0-10

What are your symptoms today? ___ / 10

When they are at their worst? ___ / 10

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8. Which activities cause or aggravate your symptoms? Mark all that apply.

Sitting greater than _____ minutes
Walking greater than _____ minutes
Standing greater than _____ minutes
Changing positions (ie., sit to stand)
Lying on your side
Stairs (going up or down)

Lifting weight overhead
Moving arm overhead/out to side
Light activity (light housework)
With cough, sneeze, straining
With laughing or yelling
With lifting/bending

With nervousness/anxiety
Lying on your stomach or back
Running in straight line, jumping or pivoting
Pushing/pulling on an object
Moving arm behind your back
Vigorous activity/exercise

Other, please list below.

9. Which activities alleviate or lessen your symptoms? Mark all that apply.

Lying on your back, legs straight
Sitting upright with support
Reclining
Changing position frequently

Ice
Rest
Lying on your stomach
Lying on your back, knees bent

Standing
Exercising
Heat
Walking

Other, please list below.

10. Describe previous treatments/exercises (including physical therapy, massage, chiropractic, etc.).

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11. How has your lifestyle/quality of life been changed because of this problem? Please specify below.

Social activities

Physical activities

Work

Other

12. What are your treatment goals/concerns?

13. One month prior to the onset of your current episode, and since that time, have you had:

	Yes	No		Yes	No
Fever/chills			Malaise (unexplained tiredness)		
Unexplained weight loss			Unexplained muscle weakness		
Dizziness or fainting			Night pain/sweats		
Change in bowel or bladder function			Bilateral numbness/tingling		
Numbness/tingling to pelvic area			Changes in sexual function		

Other, please list below: