WASATCH PHYSICAL THERAPY & REHABILITATION CENTER

3920 S. 1100 E. Suite #115 Millcreek, UT 84124 Voice 801-713-0610 Fax 801-713-0613

PATIENT HISTORY

DATE: _____

Gender: M F

Patient Name:_____ DOB: _____AGE: _____

Referring Physician:_____ Phone #:_____

OCCUPATION:_____

MARITAL STATUS: M S W D HELP AT HOME: Y OR N STAIRS: Y OR N

MEDICATIONS: _____

_____

CHIEF COMPLAINT:_____Side: Left / Right

Auto Accident Y N **Work Injury Y N** **Other Injury Y N** **No Injury**
Date of Accident _____ **Date of Accident _____** **Date of Injury_____** **Onset_____**

HISTORY OF CURRENT COMPLAINT:_____

_____Surgery Date:_____

PAST MEDICAL HISTORY:_____

_____

PAIN IS WORST IN: AM / AS DAY PROGRESSES / PM

PAIN INTENSITY: No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room Pain

LOCATION OF PAIN:_____

AGGRAVATING FACTORS:_____

ALLEVIATING FACTORS: _____

PRIOR ACTIVITY LEVEL:_____

Are you currently receiving any Home Based Care?_____

PREVIOUS PHYSICAL THERAPY VISITS THIS YEAR: ( ) YES ( ) NO

HOW MANY SESSIONS: _____