The Physical Therapy Specialty Center

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"Our Head, Hearts and Hands Helping You to Better Health"

PATIENT HISTORY FORM – *Concussion*

PLEASE PRINT

NAME: _____

Age: _____ Most Recent Doctors Appt: _____

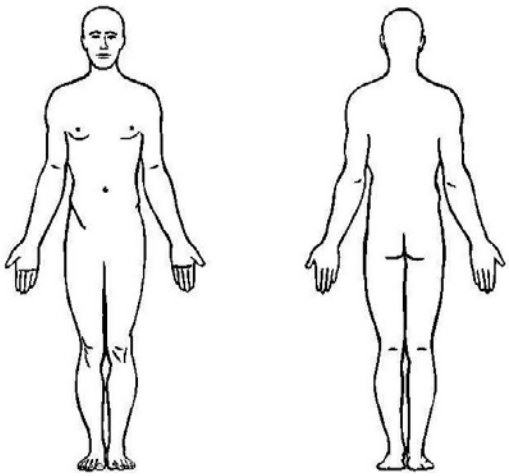
When did you sustain your concussion? _____

Do you have any accommodations in place (work/school)? _____

Have you had prior concussions? _____ when?_____ how many?_____

Is the problem the result of a car accident? Yes_____ No_____
Or workplace accident? Yes_____ No_____

Have you received home health in the last 30 days? Yes____ No____



Please mark on the drawing where your pain is

Please check if you have experienced any of the following conditions:

Recent unexplained weight loss _____
Involuntary loss of urine or stool _____
Severe night pain or sweats _____
Severe headaches_____
Recent fall or trauma _____
Difficulty coordinating legs while walking_____
Recent high fever _____
Numbness in groin _____
Weakness of hands _____
Neck pain _____
Back Pain _____

Please circle one:

Rate your headache:(1=minimal 10=severe) At its **worst**: 0 1 2 3 4 5 6 7 8 9 10 At its **best**: 0 1 2 3 4 5 6 7 8 9 10
Rate your dizziness:(1=minimal 10=severe) At its **worst**: 0 1 2 3 4 5 6 7 8 9 10 At its **best**: 0 1 2 3 4 5 6 7 8 9 10

Have you had any other treatment for this condition? Yes_____ No_____

If Yes, please check: Chiropractic _____ CT Scan_____ EMG/NCV_____ Injections_____ Medication_____
MRI_____ Surgery_____ X-ray_____ Other_____

Do you have any of the following conditions? *(Please check all that apply)*

Anxiety/Nervousness_____ Cancer_____ Circulatory Prob._____ Diabetes_____
Dizzy Spells_____ Heart Disease/Trouble_____ High Blood Pressure_____ HIV/HEP-C_____
History of steroid usage____ Osteoarthritis_____ Pacemaker_____ Rheumatoid Arthritis_____
Skin Disorders/Sensitivity____ Pregnant_____ Vision trouble/Hearing Loss _____ Other_____

Do you have metal implanted in your body? YES_____ **NO**_____ If yes, where? _____

List all **Prescription MEDICATIONS** you are currently taking_____

Have you ever had Physical Therapy? Yes_____ No_____ If yes, indicate at what office and for what_____
Within this year have you been seen at another physical therapy clinic? Yes____ No____ How many visits_____

HOW DID YOU HEAR ABOUT US? Doctor_____ Friend ____ Other (please describe) _____

AUTHORIZATION FOR MEDICAL TREATMENT AND AUTHORIZATION FOR RELEASE OF INFORMATION

I consent to physical therapy treatment/provisions of modalities and procedures, as indicated by the therapist and/or physician. I have reviewed and agree with all office policies including Attendance and Patient Rights and Responsibilities.

PATIENT SIGNATURE: _____ **DATE**: _____
GUARDIAN'S SIGNATURE (if patient is under 18): _____