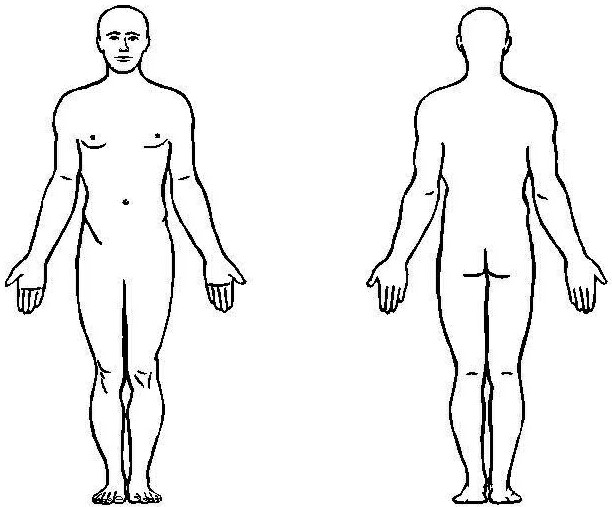


# PATIENT HISTORY FORM – *Concussion* PLEASE PRINT



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? Yes\_\_\_\_ No\_\_\_\_ Agency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Recent unexplained weight loss \_\_\_\_\_ Recent high fever \_\_\_\_\_\_\_

Involuntary loss of urine or stool \_\_\_\_\_ Numbness in groin \_\_\_\_\_\_

|  |  |
| --- | --- |
| Severe night pain or sweats \_\_\_\_\_\_\_ Weakness of hands \_\_\_\_\_  Severe headaches\_\_\_\_\_\_ Neck pain \_\_\_\_\_\_\_  Recent fall or trauma \_\_\_\_\_\_\_\_\_\_\_\_\_ Back Pain \_\_\_\_\_\_\_\_  Difficulty coordinating legs while walking\_\_\_\_\_\_\_ | **Please mark on the drawing where your pain is** |

***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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Sign up for our Newsletter****:* Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_