ABOUT YOU Physical Therapy

5622 Sheridan Lake Road
Suite 105
Rapid City, SD 57702

Phone 605-721-3307
Fax 605-721-3308
www.AboutYouPT.com

Patient Information Form

Patient Name:_____ **Date of Birth:_____**

Current pain complaint/injury/problem/surgery and Date of Onset: _____
_____
_____

Any recent x-rays, CAT scans, MRI's, or other diagnostic tests for your recent disorder? Yes – No If yes, please explain the findings as you understand them _____
_____

Health History
How would you describe your current health status? _____
_____

Do you exercise regularly: Yes – No (If yes, times per week & type of exercise) _____
_____

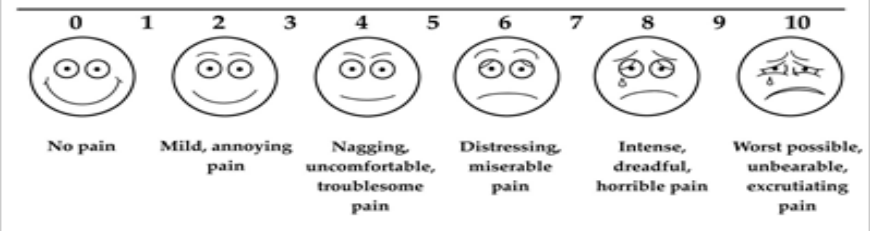
Alcohol Use: Yes - No (If yes, number of drinks per week) _____

Smoker: Yes - No (If yes, _____ Packs per day; _____ Years as User) Smokeless Tobacco: Yes_____ No_____

Social History
Right Handed:_____ Left Handed:_____
Employed:_____ Unemployed:_____ Student:_____ Work at Home:_____
Occupation:_____
Marital Status: Single:_____ Married:_____ Divorced:_____ Separated:_____ Widow:_____
Height:_____ Weight:_____

Please list all **CURRENT** Medications OR **Provide Medication List?_____Yes _____No**
Drug/Medication Name ***Reason for Medication***

PLEASE RATE YOUR PAIN:



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Medical History

Past Medical History: Please list/update all your medical illnesses, conditions and hospitalizations/surgeries.

Hospit./Surgery ***Year Diagnosed*** ***Complications – Comments***

ARE YOU ALLERGIC TO LATEX? YES – NO _____

Describe the type of reaction (rash, hives, vomiting, nausea, diarrhea, shortness of breath, other)

Review of Systems: Please indicate any current or recent problems. If yes, please describe.

	Yes	No	
Acute Hernia:	☐	☐	_____
Acute Tendonitis:	☐	☐	_____
Arthritis :(RA or OA)	☐	☐	_____
Artificial Joints (past year):	☐	☐	_____
Balance Problems:	☐	☐	_____
Blackout/Fainting/Dizzy:	☐	☐	_____
Blood Clots:	☐	☐	_____
Cancer:	☐	☐	_____
Diabetes:	☐	☐	_____
Digestion:	☐	☐	_____
Disc Problems:	☐	☐	_____
Eyes: (retinal condition)	☐	☐	_____
Fractures:	☐	☐	_____
Gout:	☐	☐	_____
Gall Stones:	☐	☐	_____
Heart Problems:	☐	☐	_____
High-Blood Pressure:	☐	☐	_____
Head Injuries:	☐	☐	_____
Kidney Problems:	☐	☐	_____
Leg Ulcers:	☐	☐	_____
Migraines:	☐	☐	_____
Pace Maker:	☐	☐	_____
Pregnant:	☐	☐	_____
Recent wounds (surgery):	☐	☐	_____
Recent Infections:	☐	☐	_____
Recently placed IUD:	☐	☐	_____
Recent pins/screws/plates:	☐	☐	_____
Seizures:	☐	☐	_____
Spondylosis:	☐	☐	_____
Stomach Digestive Problems:	☐	☐	_____
Stroke/TIA Problems:	☐	☐	_____
TB:	☐	☐	_____

	Yes	No	
AIDS/Hepatitis:	☐	☐	_____
Bowel or Bladder Problem:	☐	☐	_____
Circulation Problems:	☐	☐	_____
Ears, Nose, Throat:	☐	☐	_____
Lungs, Breathing:	☐	☐	_____
Numbness/Tingling:	☐	☐	_____
Osteoporosis:	☐	☐	_____
Psychological Problems:	☐	☐	_____
Recent Weight Loss:	☐	☐	_____
Stomach Ulcers/Reflux:	☐	☐	_____
Thyroid Problems:	☐	☐	_____
Hypoglycemia:	☐	☐	_____
Chronic Headaches:	☐	☐	_____
Anemia:	☐	☐	_____
Shortness of Breath:	☐	☐	_____
Joint Pain:	☐	☐	_____
Fibromyalgia:	☐	☐	_____
Allergies:	☐	☐	_____
Metal Implants:	☐	☐	_____

Is there anything else you think I should know about your general health, or current conditions? Please explain and, if necessary, we can talk about it:

_____

_____