PPTS Patient Health Summary

Name: ________________________ Occupation/Student (grade): ________________________

Hand Dominate: R ___ L ___ Reason for being seen today: ________________________

Have you had any testing (ie. X-ray, mri, etc) for your current condition? Yes ___ No ___

If so, what tests and where were they performed: ________________________

What leisure/physical activities do you enjoy? ________________________

What activities/movements can you no longer do due to your injury? ________________________

Date of injury or when your symptoms began: ________________________

How were you injured? ________________________

Describe your current symptoms: ________________________

What makes your symptoms worse? ____________ What makes you feel better? ____________

How long can you stand? ____________ Sit? ____________ Walk? ____________

Do you have a previous history of the condition for which you are being seen today? Yes ___ No ___

If yes, explain: ________________________ Previous treatment? ____________

What are your goals for therapy? ________________________

Do you take or have you taken prednisone, or any steroidal anti-inflammatory drugs? Yes ___ No ___

Medication/Injection and condition taken/given for: ________________________

Please list any precautions your physician or treating practitioner has given you: ____________

Please check all that apply to you:

___ Cancer
___ Heart Condition
___ Tuberculosis
___ Pacemaker
___ Defibrillator
___ Lung Disease
___ Night pain
___ Unusual Weight loss/gain
___ Emphysema
___ Diabetes
___ Glaucoma
___ Asthma
___ Stroke
___ Anemia
___ Seizure
___ Infectious Disease
___ Bowel/bladder Issues
___ Emotional Problems
___ Thyroid Problems
___ Multiple Sclerosis
___ Tobacco use
___ Dizzy spells
___ Migraines/headaches
___ Prostate Condition
___ Hepatitis/kidney problems
___ High BP/hypertension
___ Phlebitis/Circulatory Problems
___ Arthritis (OA, RA)
___ Neurological Disorder
___ Osteoporosis/Osteopenia
___ Fibromyalgia

Is there anything else you feel we should be aware of (fractures, surgeries, other medical conditions):
____

Do you have any allergies (ie. Latex, tape, lotion, cortisone, etc.)? ________________________

Are you currently receiving home health services or have you within the last 4 weeks? Yes ___ No ___

Have you had any physical, occupational or speech therapy this calendar year? Yes ___ No ___

Are you currently pregnant? Yes ___ No ___

Who or what ultimately lead you to contact us?

Referred by friend or family? ____________

Referred by your doctor or dentist? ________

Facebook ________________________

Putnam Physical Therapy Website ________

Google Search ________________________

Linked In ________________________

Twitter ________________________

Instagram ________________________

Other ________________________

Circle the number that best describes your status:

0 1 2 3 4 5 6 7 8 9 10

Best *Pain* *Worst*

Please shade in the areas where you are experiencing pain.