[Form NPHF-1 rev.12/16]

SUMMERVILLE PHYSICAL THERAPY & Balance Rehabilitation for Adults

NEW PATIENT HISTORY FORM

Today's Date

NAME	SEX ☐ MALE ☐ FEMALE	AGE	DATE OF BIRTH

WHAT BRINGS YOU TO PHYSICAL THERAPY?

CURRENT PROBLEMS/SYMPTOMS	WHEN DID THE PROBLEM START?
1.	
2.	
3.	

HOW OFTEN DO YOU EXPERIENCE SYMPTOMS?

☐ 0-25% INTERMITTANTLY ☐ 26-50% OCCASIONALLY ☐ 51-75% FREQUENTLY ☐ 76-100% CONSTANTLY

ARE YOUR SYMPTOMS CHANGING? (PEASE CHECK ONE)

☐ IMPROVING ☐ NOT CHANGING ☐ GETTING WORSE

PLEASE LIST YOUR GOALS IN COMING TO PHYSICAL THERAPY

1.
2.
3.
4.

PLEASE INDICATE IF YOU HAVE/HAD ANY OF THE FOLLOWING CONDITIONS

CONDITION	YES	NO	CONDITION	YES	NO
Cancer			Osteoporosis		
Pacemaker			Diet or nutritional concerns		
Heart disease			Nausea or vomiting		
Diabetes			Osteoarthritis		
High blood pressure			Bowel or bladder problems		
Allergies			Rheumatoid arthritis		
Angina / Chest pain			Smoking		
Asthma			HIV - positive / AIDS		
Shortness of breath			Joint replacement		
Headaches / Migraines			Hepatitis		
Stroke or TIA			Recent excessive weight loss		
Hernia			Pregnant (currently)		
Changes in appetite			Seizures		
Lightheadedness/Dizziness Fainting			Frequent loss of balance / Falls		
Difficulty sleeping			Depression		
Vision (glasses/contacts)			Anxiety / Stress		
			Hard of Hearing / Hearing Aid		

PLEASE LIST ANY OTHER MEDICAL CONDITIONS, SURGERIES OR HEALTH CONCERNS NOT LISTED ABOVE

CONDITION/SURGERY	DATE

SUMMERVILLE PHYSICAL THERAPY & Balance Rehabilitation for Adults

WHICH DIAGNOSITC TESTS HAVE YOU HAD? (PLEASE CHECK ALL THAT APPLY)

☐ X-RAY ☐ MRI ☐ CT SCAN ☐ VNG ☐ BLOOD WORK ☐ PET SCAN ☐ OTHER

DO YOU HAVE PROBLEMS WITH THE FOLLOWING?

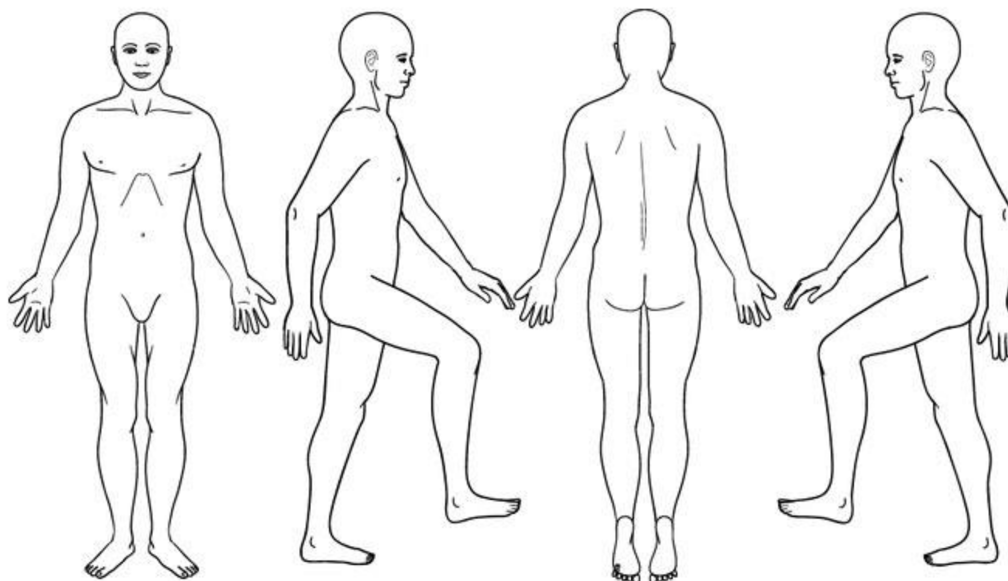
YES	NO	
		Have you fallen? If yes, have you had any fall with injury in the past year? If yes, have you had 2 or more falls in the past year?
		Difficulty walking (if so, circle all that apply: firm / uneven surfaces (i.e. grass, sand)
		Problems climbing stairs ? ☐ I must use a rail ☐ I can do stairs without a rail
		Difficulty standing still?
		Can you get up off the floor by yourself?
		Clumsiness of arms or legs?
		Weakness of arms or legs?
		Difficulty with speech?
		Difficulty with swallowing?
		Problems with memory?
		Impaired vision?
		Double vision?
		Blurred vision?
		Objects move up and down / side to side when walking or running?
		Flashes of light?
		Have you had previous problems with your ears?
		Does your hearing fluctuate or worsen with dizzy episodes?
		Facial weakness?
		Facial numbness?
		Headache or migraine (circle one if applicable)?

LIST ALL DOCTORS YOU WOULD LIKE TO RECEIVE A COPY OF YOUR PHYSICAL THERAPY EVALUATION

DOCTOR'S NAME	ADDRESS/PHONE/FAX	SPECIALTY
REFERRING MD		
PRIMARY CARE DOCTOR		
OTHER		

Body Diagram & Orthopedic Pain/Disability Scale

Please place an X on any areas involved.



What is the nature of your symptoms? (please check all that apply)

☐ Numbness / Tingling ☐ Shooting Discomfort ☐ Burning Discomfort ☐ Sharp Discomfort

☐ Dull Ache Dizziness Weakness ☐ Balance Issues ☐ Stiffness ☐ Lack of Energy ☐ Other

At <u>Best</u>: **What is the intensity level of your SYMPTOMS (pain, weakness, stiffness, dizziness)?**

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

At <u>Worst</u>: **What is the intensity level of your SYMPTOMS (pain, weakness, stiffness, dizziness)?**

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

On <u>Average</u>: **What is the intensity level of your SYMPTOMS (pain, weakness, stiffness, dizziness)?**

0 1 2 3 4 5 6 7 8 9 10

None Moderate Severe

____

Pain INCREASES during the following activities? (please list)

____

____

Pain DECREASES during the following activities? (please list)

____

____

____

All services furnished are charged directly to the patient. Patients are financially responsible for payment unless other arrangements have been made with the office management. It is our policy that payment be made at the same time services are rendered. We do not render services on the basis that insurance companies are financially responsible.

I CERTIFY THE FOREGOING STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE AND BELIEF:

SIGNATURE OF PATIENT	DATE
REVIEW BY PHYSICAL THERAPIST	DATE