171 S. Lake Ave.
P.O. Box 206
Phillips, WI 54555

sPorT plus physical therapy, LLC

"Specializing in Patient Oriented Rehabilitative Treatment"

Mel Eggebrecht, DPT

P (715) 339-6140
F (888) 412-1366
sportpluspt.com

HISTORY & PHYSICAL

Patient's Name _____ Today's Date _____

Age:_____ Date of Birth _____ Chart # _____

CURRENT CONDITION / CHIEF COMPLAINT

1. What body part will be treated today?
_____
2. Describe how it happened:_____
_____
3. When did the problem begin (date)?_____
4. Have you had surgery for this problem? ☐ Yes ☐ No
Date of surgery?_____
5. Onset? ☐ Acute ☐ Gradual
6. Pain frequency? ☐ Constant ☐ Intermittent
7. Have you had this problem before? ☐ Yes ☐ No
8. What did you do for the problem?
☐ Physical Therapy ☐ Medication ☐ Physician
☐ Chiropractor ☐ Other _____
9. Did the problem get better? ☐ Yes ☐ No
10. When do you **GO BACK** to see your doctor?
_____
11. When having increased pain, what do you do to help?
☐ Ice ☐ Exercise – explain _____
☐ Heat _____
☐ Medication ☐ Rest – What position?
(please list) _____
_____ ☐ Other – Explain_____
_____ _____
12. When is the problem worse?
☐ AM ☐ PM ☐ At Night
☐ Sitting ☐ Standing ☐ Walking
☐ Other _____

13. Are you seeing anyone else for this problem?

☐ Acupuncturist	☐ Obstetrician/Gynecologist
☐ Athletic Trainer	☐ Orthopedist
☐ Cardiologist	☐ Osteopath
☐ Chiropractor	☐ Pediatrician
☐ Family Practitioner	☐ Podiatrist
☐ Internist	☐ Psychologist/Counselor
☐ Massage Therapist	☐ Physiatrist
☐ Neurologist	☐ Rheumatologist
☐ Occupational Therapist	☐ Other _____

14. Do you currently use any of the following (check all that apply):

☐ Cane	☐ Pacemaker
☐ Crutches	☐ Defibrillator
☐ Walker	☐ Bone Stimulator
☐ Manual Wheelchair	☐ TENS Unit
☐ Motorized Wheelchair	☐ Other:_____
☐ Glasses	☐ _____
☐ Hearing Aids	☐ _____
☐ Brace	☐ _____

MEDICAL HISTORY

1. Within the past year, have you had any of the following tests? (Check all that apply)

☐ Angiogram	☐ MRI
☐ Biopsy	☐ Myelogram
☐ Bone Density	☐ NCV (nerve conduction velocity)
☐ Bone Scan	☐ Pulmonary Function Test
☐ CT Scan	☐ Spinal Tap
☐ Doppler Ultrasound	☐ Stress Test (treadmill, bicycle)
☐ Echocardiogram	☐ Urine Test
☐ EKG (electrocardiogram)	☐ X-rays
☐ EMG (electromyogram)	☐ Blood Test
☐ Mammogram	☐ Other _____

2. Are you: ☐ Right-handed ☐ Left-handed

3. Please check all tests you have had for the condition to be treated today:
☐ X-ray ☐ CTscan ☐ Bone Scan
☐ MRI ☐ EMG ☐ Other _____

4. Please explain results of these tests:
_____
_____

5. Learning Barriers
☐ None ☐ Vision
☐ Hearing ☐ Unable to read
☐ Unable to understand what is read
☐ Language / needs interpreter
☐ Other _____

SOCIAL HISTORY

1. Any customs or religious beliefs or wishes that might affect care?
☐ No ☐ Yes If yes, please explain_____

2. Employment / Work (Job / School / Play)
☐ Working full-time ☐ Homemaker
☐ Regular duty ☐ Student
☐ Light duty ☐ Retired
☐ Working part-time ☐ Unemployed
☐ Regular duty ☐ Disabled
☐ Light duty
Occupation: _____
Are you currently off work due to your condition?
☐ Yes ☐ No
If "yes", what is your anticipated return to work date:_____
If "no", are you currently on work restrictions?
Please list.
_____
_____

LIVING ENVIRONMENT

1. Does your home have:
   - ☐ Stairs, no railing
   - ☐ Stairs, railing ☐ one rail ☐ two rails
   - ☐ Ramps
   - ☐ Elevator
   - ☐ Uneven terrain
   - ☐ Assistive devices (eg. Rails in bathroom)
   - ☐ Throw Rugs
   - ☐ Any other obstacles:_____
2. Where do you live?
   - ☐ House
   - ☐ Apartment
   - ☐ Assisted living/group home
   - ☐ Condo
   - ☐ Other: _____
3. With whom do you live? (Check all that apply)
   - ☐ Alone ☐Others: (please list)

SURGICAL HISTORY

Have you ever had any other surgery? ☐ Yes ☐ No
If yes, please describe and include dates:

_____
_____
_____
_____

Hospitalizations during the **past year**:

_____
_____
_____
_____

MEDICAL/SURGICAL HISTORY

Please check if you have EVER had OR DO have:

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Broken bones/fractures
- ☐ Osteoporosis
- ☐ Blood disorders
- ☐ Circulation/vascular problems blood clots
- ☐ Heart problems
- ☐ High blood pressure
- ☐ Lung problems
- ☐ Stroke
- ☐ Diabetes-IDDM
- ☐ Diabetes – NIDDM
- ☐ Head Injury
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ HIV/AIDS
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ Allergies_____
- ☐ Other _____
- ☐ Alzheimer's disease
- ☐ Lyme Disease
- ☐ Parkinson's disease
- ☐ Seizures/epilepsy
- ☐ Allergy to latex
- ☐ Developmental or growth problems
- ☐ Thyroid problems
- ☐ Cancer
- ☐ Infectious disease (eg. tuberculosis, hepatitis)
- ☐ Kidney problems
- ☐ Repeated infections
- ☐ Ulcers/stomach problems
- ☐ Skin diseases
- ☐ Depression
- ☐ Fibromyalgia

Any other bone/joint/muscle injuries or pathologies in the past:

_____
_____
_____

FUNCTIONAL STATUS / ACTIVITY LEVEL

Please list the three activities that are most difficult for you because of this current injury:

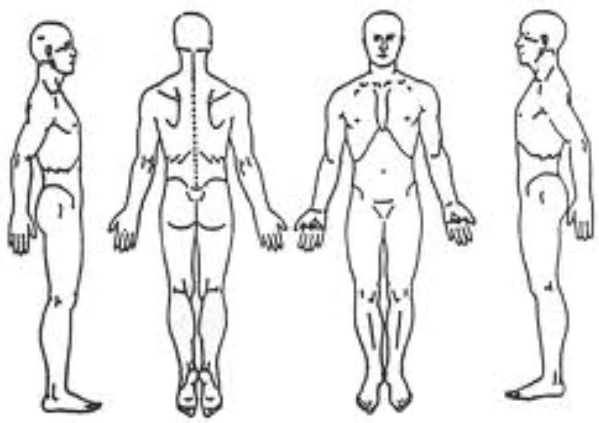
1. _____
2. _____
3. _____

What normal activities do you want to return to after completing physical therapy other than those listed above?

1. _____
2. _____
3. _____

PART ONE: Please use the diagram below to indicate the symptoms you have experienced the last 24 hours. Use the key to indicate the type of symptoms.

Key: Pins and Needles = oooooo Stabbing = //////////
Burning = xxxxxx Deep Ache = zzzzzz



PART TWO: Please circle the number that best answers each of the questions below:

What is your pain at its **WORST**?

No pain_____You've gone to the ER pain

0 1 2 3 4 5 6 7 8 9 10

What is your pain at its **BEST**?

No pain_____You've gone to the ER pain

0 1 2 3 4 5 6 7 8 9 10

What is your **CURRENT** pain level?

No pain_____You've gone to the ER pain

0 1 2 3 4 5 6 7 8 9 10

In your current condition, what percentage of your daily activity do you think you are functioning at? _____%