RJN Physical Therapy
3 Atrium Drive, Suite 110
Albany, NY 12205

Ph: (518) 489-2020 Fax: (518) 489-0716

PATIENT HISTORY FORM

PATIENT NAME:_____ DOB:_____ DATE:_____

**Please check all the answers and fill in blanks *where appropriate*. Not all questions will apply to your specific condition. Please consider the present complaints or symptoms that brought you to this clinic. Thank you!

THIS IS A TWO-SIDED FORM!!!

1.) How did your problem, condition, injury begin?

☐ Sudden onset/No specific reason ☐ Gradually developed over time ☐ Work-related ☐ Car Accident
☐ Sports-related ☐ After an incident of Falling ☐ Post-surgical ☐ Other: _____
Please provide any additional details: _____

_____

2.) When did your problem begin? Provide exact date if possible (i.e. Mo/Day/Yr or Mo/Yr): _____
If you had recent surgery, what was the date? _____

3.) Use the following (VAS) scale to rate your pain on a 0-10 scale:

0-No pain, 1-Very Weak pain, 2-Weak pain,
3-Annoying pain, 4-Minimal pain,
5-Moderate pain, 6-Somewhat Strong pain,
7-Strong pain, 8-Very Strong pain
9-Unbearable pain; 10 Excruciating pain

Provide an answer for each question below:

Currently/Today= / 10
At Worst= / 10
At Best= / 10
☐ I Do Not Experience Pain (check if applicable)

**Note: A pain rating of 5/10 indicates that symptoms are bad enough to require the use of medication for relief. A pain rating of 10/10 indicates that you should be going to the EMERGENCY ROOM.

4.) How often are your symptoms present *on average* throughout the day?

☐ Constant (76-100% of day) ☐ Frequent (51-75% of day) ☐ Intermittent (26-50% of day)
☐ Occasional (10-25% of day) ☐ Rare (<10% of day) **It is understood that pain may vary during the day. Please provide your *best* answer w/ regard to the amount of time during the day you experience symptoms.

5.) Please describe your pain or symptoms (Check all that apply):

☐ Tightness/Heaviness ☐ Weakness ☐ Numbness/Tingling ☐ Coldness ☐ Burning ☐ Dull Ache (Like a "toothache")
☐ Throbbing/Gnawing ("Deep" pain) ☐ Sharp/Stabbing ☐ Shooting/Radiating ☐ Other:_____

6.) Does your pain or other symptoms wake you up at night? ☐ YES ☐ NO ☐ SOMETIMES

7.) What is your Occupation (if applicable)?_____
Are you presently working? ☐ YES ☐ NO If YES, ☐ Full Time ☐ Part Time ☐ Light Duty ☐ No Restrictions

Describe duties/responsibilities: _____