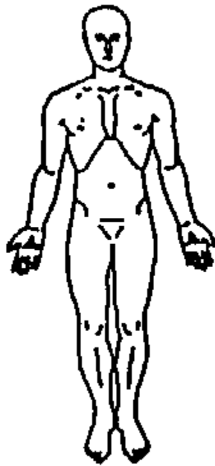
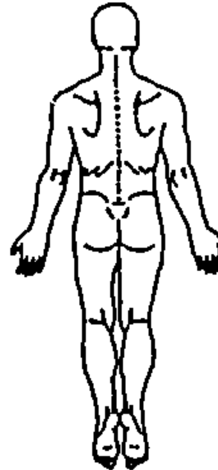
SENTARA™

PATIENT HISTORY SHEET

NAME: ____AGE:____________
REFERRING PHYSICIAN:____
Chief complaint/Describe your symptoms: ________________________________
____
____
____
When did symptoms begin?____
Have you received treatment for this condition before? If yes, what type of treatment and for how long?____
____
____

PLEASE MARK AREAS OF PAIN ON THE BODY DIAGRAM:





PLEASE CIRCLE THE FOLLOWING MEDICAL CONDITIONS THAT APPLY TO YOU:

high blood pressure	**diabetes**	**cancer**	**heart problems**
arthritis	**osteoporosis**	**dizziness**	**lung problems**
migraines	**allergies**	**pregnancy**	**circulation problems**

Other medical problems not listed above:____________________________________
____
Previous injuries/accidents and dates:_______________________________________
____
MEDICATIONS:____
____
OCCUPATION:____
Typical job duties:____
____
HOBBIES/SOCIAL ACTIVITIES:____
What are your goals for physical therapy?:______________________________________
____