## **Seawolf Physical Therapy**

## Patient History/Self Assessment

Patient Name:		DC	OB:	Height: Weig	Weight:	
CAL HISTORY/S	SUMM	ARY LIST:				
es	Y/N	Stroke	Y/N	Unexplained Weight loss/gain	Y/N	
ing Difficulties	Y/N	Heart Trouble	Y/N	Cancer	Y/N	
-	-			Numbness/Tingling	Y/N	
				Tape allergy	Y/N	
co Use	Y/N	Osteoporosis	Y/N	Adverse response to needles?	Y/N	
ies/Injections:_						
ations:						
When did you	ır cymi	otoms hogin?				
Mark where y	our pa	ain/symptoms a	re on t	he diagram below:		
_		0				
<b>R</b> }	π		36	5. How bad is your pa	in today?	
D M	P		<u> </u>	0 1 2 3 4 5 6	7 8 9 10	
650	July .	14/1/11	wi)		1111	
	11/4	1/1:1/1	3	NO	WORST	
WH TWI	1 mg	@ ( \ ) \ \ \ (	MM	PAIN	PAIN	
1 4	14	1.16	14			
()	X)	(1)	()			
1,( )	#(	))((	J.J			
	96	00 -	1000			
What makes	sympto	oms worse?				
What makes	sympto	oms better?				
				?		
Work /home	restric	tions due to cor	ndition			
	cal HISTORY/Ses ing Difficulties is/Gout lood Pressure to Use ies/Injections: es: When did you Date of surge Have you had Results: Mark where you had a control of the c	CAL HISTORY/SUMM. es Y/N ing Difficulties Y/N is/Gout Y/N lood Pressure Y/N co Use Y/N  ies/Injections: es:  When did your symp Date of surgery (if a Have you had X-rays Results: Mark where your pa	CAL HISTORY/SUMMARY LIST:  es	CAL HISTORY/SUMMARY LIST:  es Y/N Stroke Y/N  ing Difficulties Y/N Heart Trouble Y/N  is/Gout Y/N Fractures Y/N  lood Pressure Y/N Depression Y/N  co Use Y/N Osteoporosis Y/N  ies/Injections:  es:  When did your symptoms begin?  Date of surgery (if applicable):  Have you had X-rays, CT scans, or MRI?  Results:  Mark where your pain/symptoms are on t	DOB: Height: Weight Name: DOB: Height: Weight Name: DOB: Height: Weight Name: DOB: Height: Weight Name: No	

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What goals do you have for therapy?	_
	_
	_
Extra space for other pertinent information:	_
	_