CORNERSTONE
PHYSICAL THERAPY & BEHAVIORAL HEALTH

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ADULT MEDICAL HISTORY

Patient's Name: _____ Date: _____

1. Please indicate your present medical status: illness, disease, pain, fracture: _____
   _____
   _____
   _____
2. Please indicate your past history of health: illness, disease, pain, fracture: _____
   _____
   _____
   _____
3. List all trauma and when it occurred. All trauma, accidents, and injuries are important, not just recent ones:
   _____
   _____
   _____
4. List operations you have undergone with approximate dates: _____
   _____
   _____
   _____
5. List all medications you are presently taking (and dosage): _____
   _____
   _____
   _____
6. List specialists, doctors you have seen and approximate dates: _____
   _____
   _____
   _____
7. How would you rate your current pain on a scale of 1-10 (0 =no pain, 10 = unbearable pain) _____

FUNCTION:

How many hours do you sleep at night: _____
How many hours per day (per 24 hours) do you spend out of bed: _____
Do you snore: YES ____ NO ____
How would you consider your present level of activity: POOR____ FAIR____ GOOD____
Please list your present hobbies:
_____
_____
Describe any regular exercise or sport you presently do:
_____
_____

Please indicate your ability with the following activities:

	Slightly Difficult	Great Difficulty	Slightly Painful	Severely Painful	Not Applicable
Lying on back					
Lying on stomach					
Lying on RIGHT side					
Lying on LEFT side					
Turning over back to stomach					
Turning over stomach to back					
Kneeling					
Sitting in chair					
Sitting on sofa					
Sitting in car					
Driving					
Driving (REVERSE)					
Standing from FLOOR					
Standing from BED					
Standing from CHAIR					
Standing up STRAIGHT					
Walking					
Running					
Bending (vacuuming)					
Lifting objects from floor					
Lifting objects from table					
Reaching over head					
Dressing/Undressing					
Bathroom/Hygiene					
Sports					
Work					
Housework					
Meal Preparation					
Feeding Self					

8. In your words, what do you feel is your primary problem: _____

_____

_____

History of Treatment:

Please indicate the method you have used to decrease your pain by filling in how often used and rate the effectiveness on the following scale (W = worse, 0=no effect, 1= little effect, 2 = fair, 3 = good, 4 = excellent)

	Never	Once a month	Once a week	Twice a week	Once a day	More than once a day
Medications						
Exercise						
Bed Rest						
Heat/Cold						
Biofeedback/relaxation/imagery						
Physical Therapy						

Chiropractic						
Massage						
Individual Psychotherapy						
Group Psychotherapy						
Brace Equipment						
TENS						
Ignore Pain						
Chiropractic						

1. If the chart on the previous page/above was not sufficient to describe your method of pain control, please add detail:_____

_____

2. Symptoms — please check the following:

	Never	Mild/occasional	Moderate/often	Severe/constant
Dizziness				
Nausea				
Ringing ears, painful ears				
Vision: blurring, burning, aching, pressure, change in vision				
Decreased concentration/attention				
Short-term memory loss				
Allergies, sinus				
Cold/hands and feet				
Stiffness				
Balance/coordination problems				
Bowel/bladder problems				
Sexual function problems				

3. Please indicate what makes the symptoms worse:

____lying down ____sitting ____standing
____walking ____running ____driving
____working ____time of day ____too much activity
____bending ____reaching ____lifting
____squatting ____kneeling ____too little activity
____other (please specify): _____

4. What makes your symptoms decrease: _____

_____

5. Was the onset of symptoms: SUDDEN____GRADUAL _____ Explain (if necessary): _____

_____

6. When did your symptoms begin (weeks - months - years): _____

GOALS:

1. What do you feel needs to be done to begin your recovery: _____

_____

_____

2. What are your goals from therapy: _____

_____