Momentum Physical Therapy

Patient History Form

Name: _____ Date: _____

Date of Injury: _____

Briefly describe your symptoms: _____

_____

_____

Current treatment for injury: _____

_____

Diagnostic testing: _____

_____

Current Medications: _____

_____

Do you have or have you ever had:

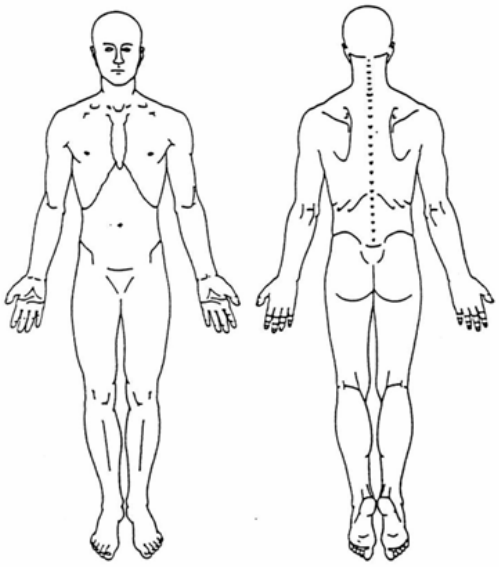
	Cancer		Osteoporosis/Osteopenia
	Stroke		Lung Problems
	Diabetes		Arthritis
	Heart Condition		Neurologic Condition
	High Blood Pressure		Head Injury
	Allergies		Surgery

Please describe anything you checked: _____

_____

Body Diagram

Instructions:
On the body diagram below, please indicate where your pain is located at the present time. Please do not indicate areas of pain that are not related to your present injury or condition,



Indicate on the line below how you would describe your present pain by placing a mark on the line between the two extremes of experiencing no pain at all and experiencing the worst pain you have ever felt.