PICTURE

DX:

TX:

Patient Information Form

Name:____ **Date:** ____ / ___ / ____
First Name Last Name Middle Name DD MM YY

Local Adress:____
Street City State Zip

Home Phone:________________ **Cell:** ________________**Day of Birth**: ____ / ___ / ____ **Age** _____
DD MM YY

Email:____ **Gender: M** ☐ **F** ☐

Primary physician: ______________________________ **Do you have WhatsApp ?** **Yes** ☐ **No** ☐

PLEASE TELL US HOW YOU LEARNED OF OUR SERVICE OR WHOM WE MAY THANK

☐ I was former Patient ☐ Found you on the Internet ☐ Family/Friend ☐ Doctor Recommendation

Where:_______________ Who:_______ Who:_______________

History of Current Condition:

1. Date of injury or onset of pain: ____
2. List previous treatments for this condition: ______________________________________
3. List previous episodes of similar pain: ____
4. Pain location at time of onset: ____
5. Pain location today: ____
6. Chief complaint: ____
7. What makes symptoms better: ____
8. What makes symptoms worse: ____
9. Does the pain wake you at night: ____
10. Do you feel rested when you wake? Yes ☐ No ☐
11. Pain scale (0 = no pain; 10 = a lot of pain) Present: _______Worst:______ Best: _______
12. Pattern of pain during day (0 = no pain, 10 = emergency room) AM:_____ Noon:_____ PM: _____

Past Medical/Surgical History:

1. *Current & previous health problems:*
☐ Heart ☐ Lungs ☐ Diabetes ☐ Stomach ☐ Neurological ☐ Cancer ☐ Musculoskeletal
☐ Osteoporosis ☐ Incontinence ☐ Fractures ☐ Prosthesis ☐ Surgeries
If you Marked, please explain: ____
____

2. Balance: ☐ Poor ☐ Normal
3. Fall History: Fall in the past six months ☐ *Yes* ☐ *No How many Times:*_________________________
4. *General Health:* ☐ Excellent ☐ Good ☐ Fair ☐ Poor
5. Blood pressure is under control? Yes No if your answer is yes, please specify how do you keep it under control____
6. Do you have a pacemaker: Yes ☐ No ☐ if your answer is yes, when was the date of your procedure? ____
7. Blood Thinners: ☐ Yes ☐ No
8. Smoker: ☐ Yes ☐ No Packs/day ___________
9. Alcohol: ☐ Yes ☐ No Amount: _____________
10. Caffeine: ☐ Yes ☐ No Amount: _____________
11. Water intake per day (ounces): ____________________

Physiotherapist Notes:

____

Patient / Patient Representative Signature: ____________________ Date____/____/____

REV: 28th/April /2022

Ulloa PHYSICAL THERAPY CENTER