Confidential Patient Case History

Please complete this questionnaire in its entirety. This confidential medical history will be part of your permanent records. Provide as much detail as possible to provide your therapist with a comprehensive overview of your case and present condition. Thank you!

Patient's Full Name _____**Nickname**_____ **Birthday** _____

How did you first hear about Synergy?

○ Workshop ○ Email ○ Physician ○ Workman's Comp ○ Website ○ Facebook ○ Friend/Family_____

Address:_____ **City** _____ **State**_____ **Zip**_____
Home Phone:_____ **Cell Phone:** _____**Work Phone:**_____ **Ext.**_____
EMAIL: _____ **May we leave a voice message if necessary? ❑Yes ❑No**
Social Security Number:_____ **Marital Status: ❑M ❑S ❑D ❑W ❑P Sex: ❑M ❑F**
Occupation: _____ **Employer:**_____
Emergency Contact Name/ Relation: _____/_____**Phone#:**_____
Please list anyone in which we have permission to speak to regarding treatment or scheduling:_____

MEDICAL HISTORY

Describe in detail, what is your major complaint/ restriction(s)?_____

_____

_____

Is this condition: ❑Job related ❑Auto Accident ❑Other:_____ **Date of accident: ___/____/____**

Date of onset? _____**What caused/ preceded this condition?** _____

Does anything make this condition feel worse? _____

Does anything make this condition feel better? _____

Is this condition interfering with: ❑Work/School ❑Sleep ❑Daily Routine ❑Other:_____

Is this condition: ❑Improving ❑Unchanging ❑Getting Worse ❑ Intermittent

Other Doctors or Therapist who have treated THIS Condition (Please Provide Names)**:**_____

Prior to this injury/problem did you have limitations with your daily activities? ❑Yes ❑No If YES, please explain:

_____

Do you have a primary doctor? ❑Yes ❑No If Yes, Name: _____

Medications, dosage and frequency (or copy):_____

_____

Have you had this or similar conditions in the past? ❑Yes ❑No If YES, what date(s)?_____

Have you previously been in an auto accident or had any other personal injury? ❑Yes ❑No

If YES, please list YEAR/ INJURIES:_____

Are you receiving or have you recently received other therapy services for this condition? ❑Yes ❑No

FAMILY & SELF HISTORY

	Self	Father	Mother		Self	
High blood pressure	☐	☐	☐ Controlled? Y / N	**Infectious Disease**	☐	
Epilepsy/Seizures	☐	☐	☐ Last:_____	**Dizziness/ fainting**	☐	
Cancer	☐	☐	☐ Form:_____	**Bowel/ bladder problems**	☐	
Depression/Mental Illness	☐	☐	☐	**Severe Headaches**	☐	Days/Week_____
Heart attack/Stroke	☐	☐	☐ Date:_____	**Osteoporosis**	☐	Controlled? Y/N
Diabetes	☐	☐	☐ Type I/II	**Chest Pain**	☐	
Asthma	☐	☐	☐ Last Episode:_____	**Smoking**	☐	Ppd_____ Years_____
Drug/ Alcohol Abuse	☐	☐	☐	**Pace Maker**	☐	
Severe Allergies	☐	☐	☐ To:_____	**Blood clots**	☐	When/Where?_____

Please clarify any above checks: _____

_____

_____

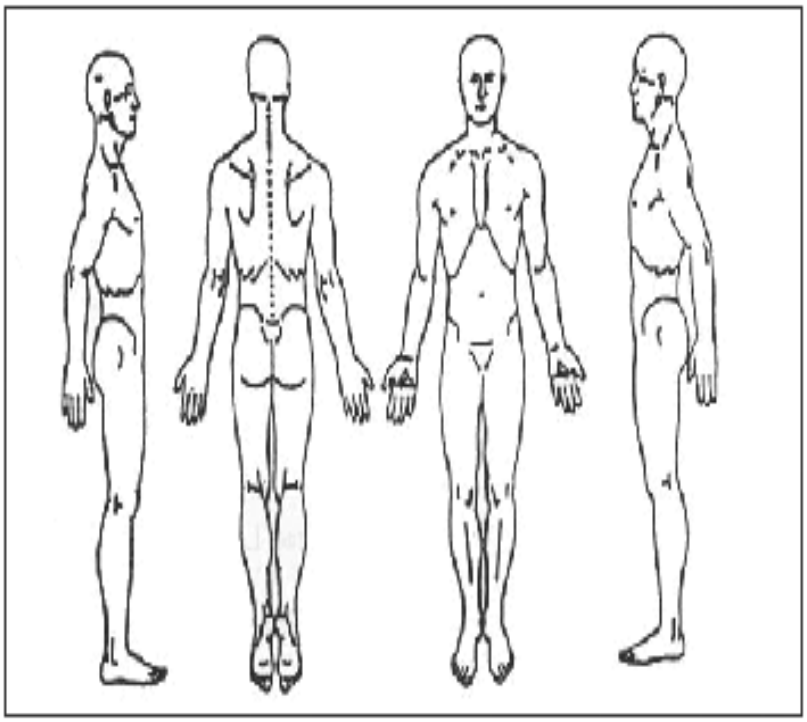
ADDITIONAL MEDICAL HISTORY

Surgeries/dates:_____

Xrays/MRI: ❑Yes ❑No Results(if known):_____

Recent Hospitalization/ Other?_____

Current Weight_____(lbs) Current Height_____(inches)



PAIN INTENSITY:
Please mark your symptoms on the figure accordingly:
! = stabbing ***** = aching **//** = burning **#** = numbness/tingling

Rate the intensity of your pain from 0 to 10 with "0" denoting no pain and "10" denoting most severe pain.

How bad are your symptoms now? ____/10

How bad have they been in the past week? ____/10

What is the least pain in the past week? ____/10

Most painful activity?_____

_____

Night pain? ❑Yes ❑No **Sleep disturbed:_____Hours**

Comments on pain:_____

_____

_____

What are your goals for physical therapy? _____

_____

One activity you would love to do that you cannot do now:_____

Women only: Are you pregnant, planning a pregnancy or nursing a child? ❑Yes ❑No

Therapist Signature: _____ Date:_____

(By signing, therapist acknowledges reviewing medical history)

Patient Signature: _____ Date: _____

(Parent/Guardian if younger than 18 years old)