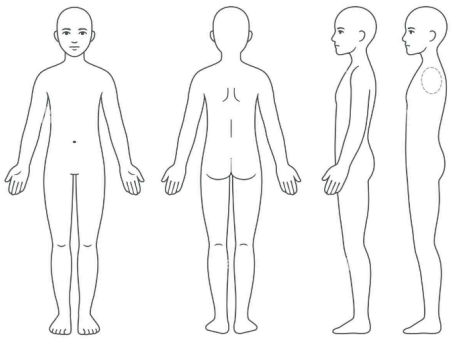
Patient Report

Full Name: _____ Preferred Name: _____ Today's Date: _____
Address: _____ Body Weight: _____ Height: _____
Date of Birth: _____ Sex Assigned at Birth: _____ Gender: _____ Pronouns: _____

Symptomatic History

When did your symptoms develop?	
Do you know why they developed?	
Are they improving, staying the same, or worsening?	
Are they constant or intermittent?	
Have you had them before?	
If you experience pain, what would you rate the pain on a scale of 0-10 (10 being extreme)?	Present: _____ Best: _____ Worst: _____
Do any activities or positions notably worsen your symptoms?	▢ Sitting ▢ Standing ▢ Walking ▢ Lying down ▢ Lifting ▢ Bending ▢ Heating ▢ Icing ▢ Coughing or sneezing ▢ Emptying bladder or bowel ▢ Other: _____
Do any activities or positions notably improve your symptoms?	▢ Sitting ▢ Standing ▢ Walking ▢ Lying down ▢ Resting ▢ Stretching ▢ Heating ▢ Icing ▢ Massaging or foam rolling ▢ Medicating ▢ Other: _____
Prior to the onset of your symptoms, what were you able to do that you would like to do again?	
With which other healthcare providers are you currently working?	▢ Physical Therapist ▢ Personal Trainer ▢ Masseuse ▢ Chiropractor ▢ Acupuncturist ▢ Midwife or OB/GYN ▢ Naturopath ▢ Nutritionist or dietician ▢ Other: _____
Have you had prior treatment/s for your symptoms?	▢ Physical Therapy ▢ Chiropractic ▢ Massage ▢ Injections ▢ Other: _____
Have you had recent diagnostic testing for your symptoms?	▢ Radiography (X-ray) ▢ CT Scan ▢ MRI ▢ EMG ▢ Other: _____
Using the legend, please identify the location of your symptoms on the following body chart: T= Tingling D= Dull ache S= Sharp pain N= Numbness B= Burning sensation R= Radiating pain O= Other: _____	

Organ Systems History

▢ Integumentary (I.e. Skin sensitivities, skin changes, new	

skin lesions, eczema, itching)	
▢ Skeletal (I.e. Bone or joint pain, osteoarthritis, osteoporosis, fractures)	
▢ Muscular (I.e. Weakness/loss of strength, global or local tightness, ache/pain specific to movement)	
▢ Nervous (I.e. Numbness, tingling, loss of sensation and/or movement)	
▢ Endocrine (I.e. Hypo- or Hyper-thyroidism, Diabetes Type II, Gestational Diabetes, night sweats, vaginal dryness, peri- or post-menopausal)	
▢ Cardiovascular (I.e. Heart problems, high blood pressure, stroke, blood clots, chest pain, dizziness/fainting, shortness of breath)	
▢ Lymphatic (I.e. Ankle swelling, enlarged lymph glands, easy bruising)	
▢ Respiratory (I.e. Breathing difficulty, past or current smoker, bouts of excessive and/or prolonged coughing)	
▢ Digestive (I.e. Heartburn, nausea and/or vomiting, irritable bowel syndrome, diarrhea, constipation)	
▢ Urinary (I.e. Kidney disease, urinary tract infection, prostate problems, interstitial cystitis)	
▢ Reproductive (I.e. Menstrual irregularities, abnormal discharge, changes in libido, pregnancy or postpartum complications, mastitis, engorgement)	
▢ Psychological (I.e. Depression, stress, anxiety, irritability, recurrent bad thoughts, mood swings, bipolar disorder, anorexia or bulimia)	
▢ Neurologic (I.e. Seizures, head injury, double vision)	
▢ Immune (I.e. Allergy, autoimmune condition)	
▢ Other (I.e. Headache/Migraine, hard-of-hearing, cancer, unexplained weight loss or gain,	

loss of appetite, general fatigue, hernia, major trauma)	

Surgical and/or Procedural History

Type	*Year/s*
▢ Vaginal birth	
▢ Caesarian-Section birth	
▢ Episiotomy	
▢ Dilation and curettage	
▢ Egg retrieval	
▢ Intrauterine insemination	
▢ Fresh or frozen embryo transfer	
▢ Hysteroscopy	
▢ Hysterectomy	
▢ Cystoscopy	
▢ Colonoscopy	
▢ Laparoscopic Surgery	
▢ Bladder surgery	
▢ Bowel surgery	
▢ Hemorrhoid surgery	
▢ Removal of adhesions	
▢ Appendectomy	
▢ Hernia repair	
▢ Breast removal, reduction, or enlargement	
▢ Gender-affirming surgery	
▢ Orthopaedic surgery	
▢ Cardiovascular surgery	
▢ Other:	

Pharmacologic History

Prescriptive Medication	Reason for taking

Non-Prescriptive Medication, Vitamins, Supplements, and/or Herbs	Reason for taking

Lifestyle History

What does your typical day look like?	
What do you eat?	▢ Balanced diet ▢ High-protein diet ▢ High-fat diet ▢ Processed food ▢ Sugary food
Are you on a special diet? If so, please describe it.	
What do you drink?	▢ Still water ▢ Sparkling water ▢ Soda ▢ Coffee or tea ▢ Alcohol
What is your general activity level?	▢ Sedentary ▢ Somewhat active ▢ Very active
What activities are important to you?	
How often do you exercise?	▢ 5+ days/week ▢ 3-4 days/week ▢ 1-2 days/week ▢ 0 days/week
What is your preferred kind of exercise?	
How many hours of continuous sleep do you have per night?	
Do you have trouble falling or staying asleep?	
Do you use back-lit screens/devices 2 hours or less before bedtime?	
What is your stress level on a regular basis?	▢ None ▢ Mild ▢ Considerable ▢ Significant
What is your relationship status?	▢ Married/Partnered ▢ Single ▢ Widowed ▢ Divorced
If you are in a relationship, what level of tension do you experience in it?	▢ None ▢ Mild ▢ Considerable ▢ Significant ▢ N/A
Are there barriers that may make it difficult for you to participate in Physical Therapy?	
What would you like to accomplish with Physical Therapy?	

_____

Patient Name

_____

Patient Signature Date

_____

Parent/Guardian Signature Date