Parmenter Physical Therapy

Medical History/Pain Screen

Patient Name_____ Date:_____

Have you ever had trouble with or been diagnosed with? If yes, please explain.

Heart trouble Y N _____

Circulatory Trouble Y N _____

High Blood Pressure Y N _____

High Cholesterol Y N _____

Diabetes Y N _____

Thyroid Y N _____

Dizzy Spells Y N _____

Cancer Y N _____

Any other illnesses_____

Do you have problems with your vision or hearing_____

Please list current medications and dosage _____

_____

Please list major surgeries and orthopedic surgeries and dates: _____

_____

Pain Level from 0-10

Current _____ Highest _____

Please check nature of pain:

_____ Burning _____ Sharp _____ Ache _____Shooting _____ Numbness _____ Tingling

_____ Constant ____Intermittent

Do you have difficulty sleeping _____