Riverside Physical Therapy
486 White Mountain Highway, Suite E
Conway, NH 03818
207-223-3465 Fax 207.203.6233
www.riversideptnh.com

Symptom History

Patient Name:_____

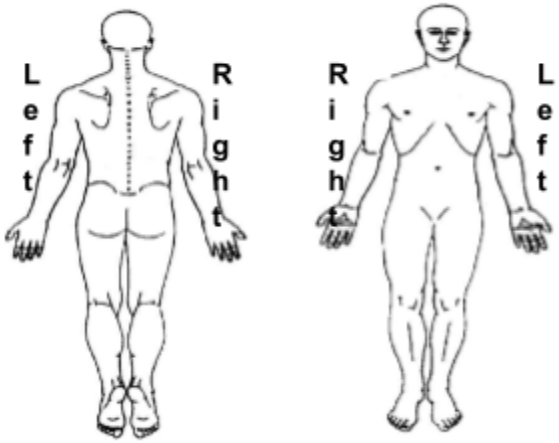
Diagnosis:_____

Date of Injury / Surgery:_____

Have you ever had this type of injury before? □ **Yes** □ **No** **If yes, please explain:** _____

_____

Where are your symptoms for which you are seeking treatment? *Mark the areas below where you feel your symptoms.*



What was your worst pain rating within the last 2 days? *Please circle below*

- **What makes your symptoms worse?**_____
- **What, if anything, eases your symptoms?**_____
- **Currently would you say that your health is EXCELLENT, VERY GOOD, FAIR, or POOR?** ***(Circle one)***
- **What would you like to be able to do that you currently cannot do?** ***Please list goals below***

What are your goals for Physical Therapy?

MEDICAL HISTORY

GOAL 1:_____

_____

GOAL 2:_____

_____

Do you currently have or have you had any of the following? Please check below

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema			**Cancer or Chemotherapy**		
Shortness of Breath			**Arthritis / Swollen Joints**		
Smoker			**Bowel or Bladder Problems**		
(If Yes How much?_____)			**Allergies**		
Coronary Heart Disease or Chest Pain			**Severe or Frequent Headaches**		
Pacemaker			**Vision or Hearing Difficulties**		
High Blood Pressure			**Do you have a history of falling?**		
Stroke/TIA/Head Injury/Blood Clot/Emboli			**Gout**		
Nausea or Vomiting			**Numbness or Tingling**		
Thyroid Trouble or Goiter			**Dizziness or Fainting**		
Varicose Veins			**Weight Loss / Energy Loss**		
Anemia			**Epilepsy / Seizures**		
Infectious Diseases			**Joint Replacement / Metal Implants**		
Diabetes			**Hepatitis / Liver Disease**		
Women Only: Are You Pregnant?			**Osteoporosis or Osteopenia**		

Have you received any recent medical tests or imaging?

□ Yes □ No If Yes: what? _____

MEDICATIONS (please or attach a list or list all medications you are currently taking):_____

_____

_____

SURGERIES (please list all surgeries and approximate dates):_____

_____

_____

As part of our quality program, we believe that patients should be integrally involved in their rehabilitation plan. This includes being informed about the treatment recommended, as well as the goals of your program. It is important that you understand you have the right to refuse any part of the treatment your therapist recommends.

Therapist Initials: _____

Signature/Date:_____ Indicates Reviewed