



FOOTHILLS Physical Therapy

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foothillspt.com

PATIENT HISTORY FORM

Name: _____ D.O.B _____ Age: _____

Current Conditions/Chief Complaint: _____

Describe the problem for which you seek physical therapy: _____

When did the problem begin? _____

What happened? _____

Have you ever had this problem before? If yes, explain. _____

What aggravates or makes your problem worse? _____

What eases or makes your problem better? _____

What are you currently doing to make your problem better? _____

What are your goals for physical therapy? _____

Functionally, what are you having difficulty with?
(For example: driving, walking, prolonged sitting, lifting, working....) _____

Current Medication (please list all): _____

Are you allergic to any medications? (please list all): _____

(Complete on back)

