STEAMBOAT
PHYSICAL THERAPY

**Percival Creek Professional Plaza** | 2102 Carriage Drive SW, Suite B, Olympia, WA 98502
Office 360.866.0408 | Fax 360.866.1165 | Clinic hours: Monday - Friday, 7:00 a.m. to 5:30 p.m.

# MEDICAL HISTORY: Please complete and bring to your first appointment

Name: ______________________ Age: ____ Height: ______ Weight: ______

Occupation: ______________________ Currently working? ☐ Yes ☐ No

Referring Physician: ______________________ Primary Physician: ______________________

Last appointment with Physician: ______________________ Next appointment: ______________________

I have a history of (please check all that apply):

| | | | | |
|---|---|---|---|---|
| ☐ High blood pressure | ☐ Osteoporosis | ☐ Poor circulation | ☐ Night sweats | ☐ Arthritis |
| ☐ Thyroid problems | ☐ Bowel/Bladder | ☐ Smoking/tobacco use | ☐ Diabetes | ☐ Dizziness |
| ☐ Heart trouble | ☐ Severe pain at night | ☐ Frequent falls | ☐ Fractures | ☐ Headaches |
| ☐ Asthma | ☐ Back injury | ☐ Cancer | ☐ Pacemaker | ☐ Stroke |

Other: ______________________

What activities do you have difficulties doing? ______________________

What are your goals for physical therapy? ______________________

What surgeries have you undergone? ______________________

Date of injury: ____________ How did the injury occur? ______________________

The following tests have been completed: ☐ X-ray ☐ MRI ☐ CAT ☐ EMG Other: ____________ ☐ None

Before the present pain/problem, what exercise(s) were you doing? ______________________

______________________

Have you had treatment for the current problem: ☐ Yes ☐ No What type? ______________________

Are you currently receiving physical therapy or home health treatments? ☐ Yes ☐ No If so, dates: ____________

Please check the medications that you are presently taking, or have recently taken:

| | | | | |
|---|---|---|---|---|
| ☐ Steroid (cortisone) | ☐ Anti-inflammatory | ☐ Painkiller | ☐ Heart medication | Other: ________ |
| ☐ Blood pressure | ☐ Blood thinner | ☐ Muscle relaxant | ☐ Insulin | |

Which of the following best describes your symptions?

| | | | |
|---|---|---|---|
| ☐ Sharp | ☐ Dull | ☐ Burning | ☐ Numbness |
| ☐ Constant | ☐ Intermittent | ☐ Pins and needles | Other: ________ |

Please mark activity with ( + ) that aggravates pain, and ( - ) that relieves pain:

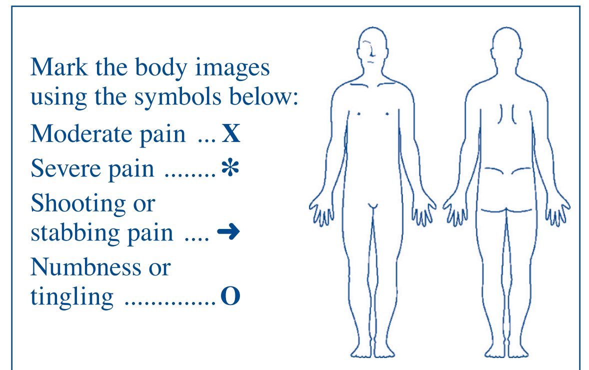
| | | | | |
|---|---|---|---|---|
| ☐ Standing | ☐ Lying down | ☐ Bending forward | ☐ Getting up or down | Other: ________ |
| ☐ Sitting | ☐ Walking | ☐ Bending backward | ☐ Cough / Sneeze | |

Please place a mark on this line to indicate the intensity of your pain:

**0**~~~~~~~~~~~~~~~~ **5** ~~~~~~~~~~~~~~~~**10**
No pain — As bad as it can be

**Authorization for treatment:**
I authorize the physical therapist of Steamboat Physical Therapy to administer such treatment as is prescribed and considered therapeutically necessary based on the findings during the course of treatment. The information provided is accurate to the best of my knowledge.

Your signature: ______________________ Date: ____________




(REV. 4/2011)