PRIVATE THERAPY SERVICES
PHYSICAL THERAPY
815 SAVANNAH HWY SUITE 101, CHARLESTON, SC 29407
PHONE: 843-766-2121 FAX: 843-766-8644

Patient Medical History

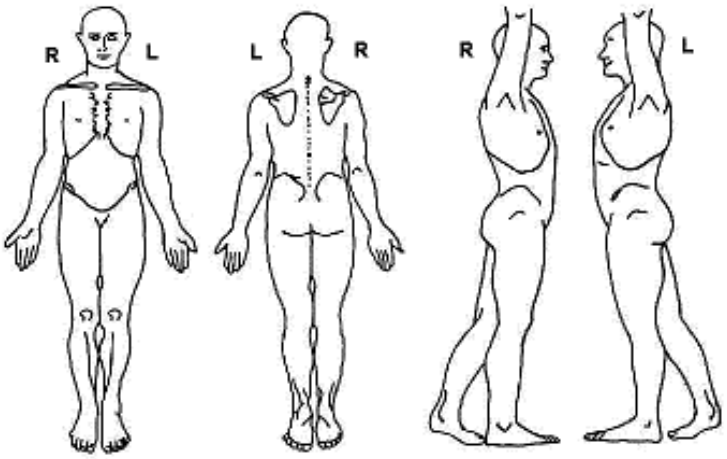
Name:_____ Today's Date:_____

Referring Physician:_____ Date of Injury/Onset:_____

How Injury happened: _____

Please mark the location of the symptoms you are currently feeling on the diagram:

X for Pain
O for Numbness
--- for Tingling



On a scale from 0-10, 0 being no pain, 5 being moderate pain, and 10 being the worst pain imaginable, please rate your pain based on the last 30 days.

	(no pain)					(moderate)					(severe pain)
TODAY	0	1	2	3	4	5	6	7	8	9	10
LOWEST (or best)	0	1	2	3	4	5	6	7	8	9	10
HIGHEST (or worst)	0	1	2	3	4	5	6	7	8	9	10

Circle what best describes your pain:

Constant Occasional Sharp Dull Aching Shooting Burning

History of Allergies?	YES	NO	List medications, previous surgeries and any other pertinent medical information:_____
History of Cancer?	YES	NO	_____
Thyroid Problems?	YES	NO	_____
Are you Diabetic?	YES	NO	_____
Are you Pregnant?	YES	NO	
Do you have a Pacemaker?	YES	NO	
Bowel/ Bladder problems?	YES	NO	**Signature**:_____
Do you have Hypertension?	YES	NO	**Date:** _____