ATLAS PHYSICAL THERAPY

MEDICAL HISTORY/PAIN CHART AND ADL SCREEN

PATIENT:_____ AGE: _____

Are you on any medications? ☐YES ☐NO Please list all prescription, over the counter and herbal medicines below as well as dosage, frequency and route of administration i. e. oral or injected

_____

_____

_____

_____

Height: ____ft _____ inches Weight:_____ lbs.

2 or more falls in the past year? ___ Y ___N Any fall in the last year resulting in injury ___Y ____N

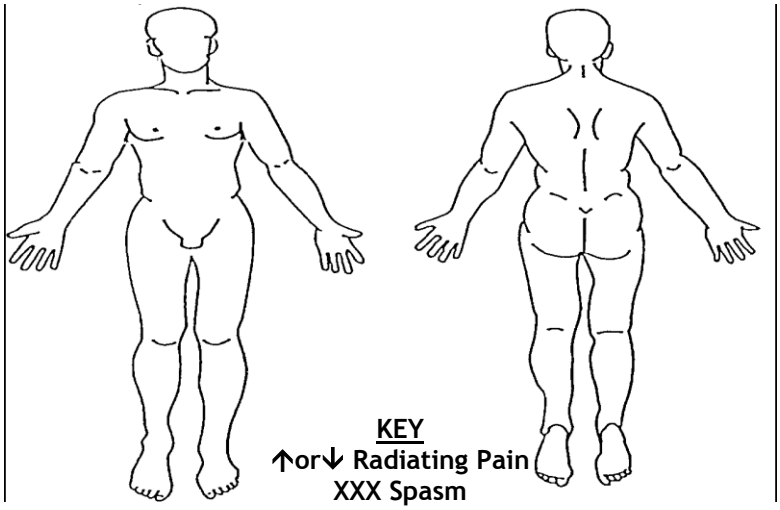
Have you ever, or are you presently being treated for any of the following conditions?

Diabetes	☐ YES	☐ NO
Headaches	☐ YES	☐ NO
Dizzy Spells	☐ YES	☐ NO
Fainting Spells	☐ YES	☐ NO
Epilepsy	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Are you currently pregnant	☐ YES	☐ NO
Seizures	☐ YES	☐ NO
Asthma	☐ YES	☐ NO
Emphysema	☐ YES	☐ NO
Osteoporosis/Osteopenia	☐ YES	☐ NO
Back injury	☐ YES	☐ NO
Arthritis	☐ YES	☐ NO
Bleeding disorder	☐ YES	☐ NO
Fracture	☐ YES	☐ NO
Cancer	☐ YES	☐ NO
Pacemaker	☐ YES	☐ NO
Metalology (implants)	☐ YES	☐ NO
Respiratory problems	☐ YES	☐ NO
Tuberculosis	☐ YES	☐ NO
Hepatitis A,B,C	☐ YES	☐ NO
MRSA	☐ YES	☐ NO
HIV/AIDS	☐ YES	☐ NO
Heart Trouble	☐ YES	☐ NO
High Blood Pressure	☐ YES	☐ NO
Bowel/bladder problems	☐ YES	☐ NO
Sudden weight loss	☐ YES	☐ NO
Allergies	☐ YES	☐ NO
List:		

Please circle all that may apply. *My pain is worse*:
In the morning/during the day/at night/constantly/
with activity/during rest.

On a scale of 0 to 10,
0 being no pain and 10 being unbearable pain requiring hospitalization,
rate your pain at its best _____ and worst _____.

Using the key provided, draw the symbol representing your pain over the area of the body as it relates to your **present** condition.



KEY
↑or↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
////// Numbness/Tingling
0000 Ache/Pain

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities? Do you have pain associated with or have you changed your method of performing any of the following tasks? **Check all that apply?**

☐Getting in/out of bed	☐Personal hygiene activities	☐Eating	☐Shaving	☐Cleaning
☐Getting in/out of car	☐Bathing/shower	☐Sleeping	☐Lifting	☐Writing
☐Getting in/out of chair	☐Brushing teeth	☐Sitting	☐Cooking	☐Shopping
☐Walking up/down stairs	☐Dressing	☐Standing	☐Laundry	☐Driving
☐Getting in/out of shower	☐Work activities	☐Walking	☐Vacuuming	

☐Other _____

✍ Patient Signature: _____ Date: _____