

Los Gatos Orthopedic Sports Therapy

PROactive Orthopedic & Sports Rehabilitation:
"One Team, One Goal"

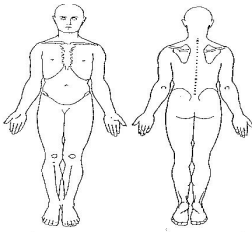
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PERSONAL MEDICAL HISTORY AND INFORMATION

NAME: _____ SS#: _____ AGE: _____
REFERRING PHYSICIAN: _____ DIAGNOSIS: _____
HAVE YOU HAD PHYSICAL THERAPY IN CURRENT YEAR? _____, IF SO, # OF VISITS _____
DATE INJURY OCCURRED? _____ HOW/MECHANISM? _____

What activities are you limited with due to your symptoms? _____
What activities **aggravates** your symptoms? _____
What activities **eases** your symptoms? _____
Do your symptoms change throughout the day? **Yes/ No** AM _____ PM _____ EOD _____
Do you have symptoms of burning, numbness or tingling? **Yes/ No** Where? _____
Have you had similar episodes before? **Yes/ No** Increase severity? **Yes/ No** Change in character **Yes/ No**
What is usual cause for reinjury? _____

Have you had surgery for this injury? **Yes/ No**, If yes when? _____



Have you been or currently being treated by any other health care professional for this condition? _____

Diagnostic Tests? X-Rays _____ MRI _____ CT Scan _____ EMG _____

MEDICAL HISTORY

Current Medications? _____

Allergies? If any _____

Please answer, **Yes or No** to the following:

- | | |
|------------------------------------|---|
| Yes/ No: Diabetes | Yes/ No: Heart disease |
| Yes/ No: Pacemaker | Yes/ No: High blood pressure |
| Yes/ No: Head trauma/convulsions | Yes/ No: Head, neck, spine surgery |
| Yes/ No: Abdominal surgery | Yes/ No: Pregnant |
| Yes/ No: Bowel or bladder changes | Yes/ No: Fractures |
| Yes/ No: Rheumatoid Arthritis | Yes/ No: Family or personal History of Cancer |
| Yes/ No: Glaucoma | Yes/ No: Osteoporosis |
| Yes/ No: Previous shoulder injury? | Yes/ No: Previous knee injury? |

Do you exercise regularly, 2-3 times per week? Yes/ No How: _____

Do you know of any reason you should not participate in an exercise program? Yes/ No Describe: _____

Any other medical condition or diagnosis we should be aware of? _____

What are your **GOALS** from physical therapy? _____

PAIN INTENSITY: In the past 24 Hours, mark a point on the line below indicating you pain.

No pain [_____] Worst pain possible

Sign & Date: _____