

Family Physical Therapy
Return Patient Updated Health Information Form

Patient Name: _____

- Describe the location of your current pain/symptoms:

- When did these current symptoms begin:

- Is this the same condition or pain we treated you before?

- Have you had any recent tests performed (X-rays, MRI, blood work, etc.):

- If yes, what were the results?

- Since your pain started are the symptoms getting: (please circle your response)
 - Worse
 - Better
 - Staying the same
- If you have pain please describe your symptoms: (please circle all that apply)
 - Sharp/Burning
 - Dull/Achy
 - Numbness and tingling
 - Radiating pain down your arm or leg
- Please rate your pain on a scale from 0-10: (0= No pain, 10=Worst pain imaginable)
 - Currently:
 - Range of pain in the past week:
- During the past week how much time has your pain/symptoms interfered with your daily tasks?
 - All the time
 - Most of the time
 - Some of the time
 - Very little
 - None
- What are you currently doing to make your condition better?
 - Taking medications (Please list) _____
 - Ice or heat
 - Exercise
 - Massage
 - Chiropractic visits / Acupuncture
- Since your last visit at this clinic, please list any changes in your medications, health conditions or insurance:

Patient Signature: _____ Date: _____