

DOB: __/__/__

ACCOUNT #:

CENTRAL UTAH CLINIC, PC

PATIENT HISTORY

THERAPIST

DATE:

Brett Mortensen M.S., P.T., A.T.C.

James Anderson M.A., P.T.

PATIENT NAME: _____ AGE:

GENDER: M or F

OCCUPATION:

OF CHILDREN:

MARITAL STATUS: M or S

HELP AT HOME: Y or N

STAIRS: # ()

MEDICATIONS:

CHIEF COMPLAINT:

HISTORY OF CURRENT COMPLAINT:

PAST MEDICAL HISTORY:

SPECIAL TEST/RESULTS:

PAIN IS WORST IN: AM or AS DAY PROGRESSES or PM

PAIN INTENSITY: No Pain 0 1 2 3 4 5 6 7 8 9 10 Emergency Room Pain

LOCATION OF PAIN:

AGGRAVATING FACTORS:

ALLEVIATING FACTORS:

PRIOR ACTIVITY LEVEL: