

# COMSTOCK PHYSICAL THERAPY PATIENT HISTORY FORM

Patient Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Please list any medications you are currently taking: \_\_\_\_\_

What do you hope to gain from physical therapy?

When did your problem begin?

**Please check if you have or have had any of the following:**

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Headache
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Back/Neck Pain
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Use of Tobacco
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	HIV+/AIDS
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Major Illness/Accident	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Reaction to Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement
<input type="checkbox"/>	<input type="checkbox"/>	Broken Bones	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Trouble
<input type="checkbox"/>	<input type="checkbox"/>	Possibly Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	Wear Orthotics
<input type="checkbox"/>	<input type="checkbox"/>	Pins/Metal in Bones	<input type="checkbox"/>	<input type="checkbox"/>	

Other: \_\_\_\_\_

The form includes four line drawings of a human body: front view, left profile view, right profile view, and back view. To the right of these diagrams is a legend for marking symptoms on the body:

- ache**: Represented by a box containing several short, parallel diagonal lines.
- burn**: Represented by a box containing several checkmarks.
- sharp**: Represented by a box containing several five-pointed stars.
- pins/needles**: Represented by a box containing several small dots.
- numb**: Represented by a box containing several horizontal dashes.
- other**: Represented by a box containing several small circles.