

MEDICAL HISTORY FORM: LOWER EXTREMITY

Name:		Age: Gender: M F Appointment date:				
How did you hear about us?	☐ PCP ☐ Privia PCF	Physical therapist	☐ Google ☐ ZocDo	© ☐ Word of mouth	☐ Other	
		REASON FOR VISIT				
What is the reason for your vis	sit today? (Please include all	relevant details)				
Location:	☐ Right	☐ Left	☐ Bilateral (Both Left	& Right)		
Do you use any of the followin	g assistive devise to walk?	☐ No assistive device	☐ Cane	☐ Crutches		
(Check all that apply)		☐ Walker	☐ Wheelchair			
Context: Is this the result of an in	jury?	Yes	□ No			
If YES , what type of injury?		Sports injury: What	sport?			
		☐ Car accident (MVA)☐ Other:				
		Date of injury:				
Work related: Did this injury occ	ur while working?	☐ Yes	□ No			
		Date of injury:				
Duration: How long have you ha	d this problem?					
Onset: How quickly did the pain start?		☐ Suddenly (Immediate onset, as in an injury)				
		☐ Gradual (slowly, ove	r time)			
Status: How has the pain change	d?	☐ Improving ☐ Worse	Resolved	☐ Stable		
For any and the second second second						
Frequency: How often is the pain present?		☐ Intermittent (comes and goes)	Constant	Rare		
Intensity: On a scale of 1-10 (10 being the most painful), how severe is the pain?		□ 1 □ 2 □ 3 □ 4	5 0 6 0 7 0 8	□ 9 □ 10		
·						
Quality: How would you describe	the pain?	☐ Aching☐ Sharp	☐ Burning☐ Throbbing	☐ Dull☐ Pinching		

Anti-inflammatory medication for this problem? Anti-inflammatory medications - Please list (e.g. Ibuprofen, Advil, Aleve): Pain (prescription) medications - Please list:	Aggravated by (what makes the pain worse?)	☐ Nothing	☐ Standing	☐ Walking
Nothing Brace/splint Elevation		Climbing stairs	Descending stairs	☐ Sitting
Exercise		☐ Activity	☐ Work	Other:
Exercise		•		
Exercise	Relieved by (what makes the pain better?)	□ Nothing	☐ Brace/splint	☐ Elevation
Massage Physical Therapy Stretching Rest Other:	, (_	
Rest				
Do you have any of the following associated symptoms? Decreased mobility (siffness)		•		in Sirelening
Decreased mobility (stiffness) Yes		□ Kesi	U Omer.	
Decreased mobility (stiffness) Yes				
Instability (giving away) Yes No No Popping or clicking Yes No No Swelling Yes No No No No Yes No No No Yes No No No Yes No No No Yes No No Yes No No No Yes No No No No No No No N		N. 1		
ocking (stuck in position)	, , ,			
Anti-inflammatory medication for this problem? Anti-inflammatory medications - Please list (e.g. Ibuprofen, Advil, Aleve): Poses the medication relieve your pain? Yes				
Have you used any medication for this problem? Anti-inflammatory medications - Please list (e.g. Ibuprofen, Advil, Aleve): Pain (prescription) medications - Please list: Does the medication relieve your pain? Yes No Temporarily/Partially maging: Have you had any of the following? X-rays Doppler U/S Date/Location of Imaging: Unsuccessful treatments: What previous treatments have you tried that have been unsuccessful? Heat Rest Physical Therapy Injection Injection Injection Inversion of yes Prest, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition?	ocking (stuck in position)	•	☐ Yes ☐ No	
Please list (e.g. lbuprofen, Advil, Aleve): Pain (prescription) medications - Please list: Yes	Night pain ☐ Yes ☐ No	Weakness	☐ Yes ☐ No	
Please list (e.g. Ibuprofen, Advil, Aleve): Pain (prescription) medications - Please list: Yes		<u> </u>		
Allower you had any of the following? No Temporarily/Partially	lave you used any medication for this problem?	Yes	☐ No	
Pain (prescription) medications - Please list: Yes	Anti-inflammatory medications			
Does the medication relieve your pain? Yes No Temporarily/Partially maging: Have you had any of the following? Xrays MRI CAT scan Doppler U/S EMG/NCV Bone Density Date/Location of Imaging: Unsuccessful treatments: What previous treatments have you tried that have been unsuccessful? Heat Ice Massage Rest Physical Therapy Injection Injection TYES, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved.				
maging: Have you had any of the following? X-rays	'ain (prescription) medications - Please list:			
maging: Have you had any of the following? X-rays				□ -
Doppler U/S Date/Location of Imaging: Doppler U/S Date/Location of Imaging:	Ooes the medication relieve your pain?	☐ Yes	⊔ No	☐ Iemporarily/Partially
Doppler U/S Date/Location of Imaging: Insuccessful treatments: What previous treatments ave you tried that have been unsuccessful? Nothing	maging: Have you had any of the following?	X-rays	□ MRI	CAT scan
Date/Location of Imaging: Date/Location of Imaging:	magnig. Have you had any or me renorming.	·		
Insuccessful treatments: What previous treatments		* *	LINO/INCV	bolie belishy
Heat Ice Massage Rest Physical Therapy Injection Injection Yes No No No No No No No N				
Heat Ice Massage Rest Physical Therapy Injection Yes No YES, please list the date(s), type of evaluations and/or eatments and whether or not your symptoms were resolved.				
Rest Physical Therapy Injection No Prescription Physical Therapy Physical Therap		□ Nothing	☐ Brace/splint	☐ Exercise
Rest Physical Therapy Injection History: In the past have you ever had another problem to his same part of your body? FYES, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition? Yes Physical Therapy Injection No	nave you tried that have been unsuccessful?	☐ Heat	☐ Ice	☐ Massage
f YES, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition?		Rest	☐ Physical Therapy	-
YES, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition?			, , , , ,	•
TYES, please list the date(s), type of evaluations and/or reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition?		Yes	□ No	
reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition? Yes	nis same part of your body?			
reatments and whether or not your symptoms were resolved. Have you had any previous surgery for this condition? Yes	YES, please list the date(s), type of evaluations and/or			
	reatments and whether or not your symptoms were resolved.			
FYES, please list the date(s) and type of evaluations and/or treatments	lave you had any previous surgery for this condition?	☐ Yes	□ No	
	Have you had any previous surgery for this condition? If YES, please list the date(s) and type of evaluations and/or to		□ No	
	Additional History	not been severed at a		
	rease itsi any other details about your pain or injury that have	nor been covered above	;	
Additional History Please list any other details about your pain or injury that have not been covered above				