COLUMBIA
PHYSICAL THERAPY

PATIENT HISTORY

Name:_____ Date:_____

1. What is your problem or injury?_____
2. How did your problem or injury begin?_____
3. When did it begin?_____
4. What is your type of work?_____
5. Are you working?
   - ☐ Yes
   - ☐ No If no, is it because of your problem?_____
6. Before this injury were you completely free of symptoms?
   - ☐ Yes
   - ☐ No
7. Have you ever had anything similar before?
   - ☐ Yes
   - ☐ No
8. What type of activity increases your symptoms?
   - ☐ Sitting
   - ☐ Standing
   - ☐ Lying down
   - ☐ Walking

   Other_____
   _____
9. Do you have any feelings of pins and needles or numbness?
   - ☐ Yes
   - ☐ No
10. Indicate on the body figure the places of discomfort.