# PTR Sports
# Patient History Form

**Name:** ______________________________ **Date:** __________

Occupation: ______________________________ Work Status: ______________

Date / Type of Surgery or Injury: ______________________________

Please briefly describe your symptoms: ______________________________

______________________________

Any Previous Treatment for this condition? ______________________________

Diagnostic Testing (x-ray /MRI etc)? ______________________________

Current medications?

______________ ______________ ______________

______________ ______________ ______________

What worsens your condition? ______________________________

What improves your condition? ______________________________

***Personal medical history:***

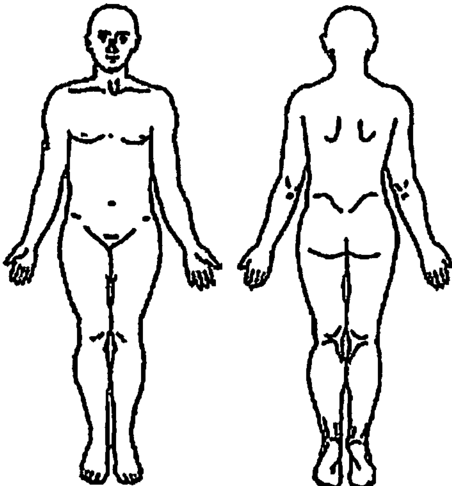
| | | | |
|---|---|---|---|
| Cancer | Heart Conditions | Arthritis | Osteoporosis |
| Depression | High blood pressure | Head injury | Broken bone |
| Stroke | Lung Problems | Stomach problems | Circulation |
| Thyroid problems | Epilepsy/Seizures | Parkinson's Disease | Skin diseases |
| Diabetes | Mental/behavioral disorders | Allergies | Fibromyalgia |
| Infectious diseases | Multiple Sclerosis | Rheumatoid arthritis | |

Other ______________________

Smoker: Y N

Exercise routine/hobbies: ______________________________
(type/frequency)

Please indicate your area of pain or abnormal symptoms that you are being seen for today by marking on the body diagram below.



***Circle Appropriate Response***

Current Pain Scale [min 1-2-3-4-5-6-7-8-9-10 max]

Nature of pain/symptoms:

Sharp Burning Aching Intermittent
Dull Throbbing Tingling Constant
Other ______________ Occasional

Since the onset of your condition, are your symptoms getting:
Better Worse No change

Experienced similar symptoms in the past? Yes No

If yes, when? ______________________________

As your day progresses do your symptoms:
Increase Decrease Stay the same

Does the pain wake you at night? Yes No