Noonan Physical Therapy & Associates — Patient History

Patient Name:______________________________ Date:_____________________________ Date of Injury:____________________

I. Please circle if you have or have had any of the following cancers.

Prostate Breast Kidney Thyroid Lung Skin Other:______________________________________

II. Please circle if you have or have had any of the following condition

Heart problems (Angina, Heart Attack, Valve)
Pace Maker
Deep venous thrombosis (blood clots in the legs
High blood pressure
Stroke
Asthma
Hernia/Hernia Repair
Chemical dependency (eg., alcoholism
Depression
Hypothyroid (low) / Hyperthyroid (high
Diabetes: Before / After age 18
Multiple sclerosis

Rheumatoid arthritis
Degenerative osteoarthritis
Gout
Ankylosing spondylitis
Hepatitis
Stomach/duodenal ulcers
Epilepsy/seizures
Headaches (more than 1 per week)
Urinary incontinence
Osteoporosis
Other illnesses diagnosed by a physician
Please list: ____

III. Please circle if you have or have had any of the following surgerie

Caesarean section/Abdominal Surgery Heart Surgery(bypass) Bone/Joint Surge (total joint replacement, knee, shoulder,hip)

Other surgeries: Please List:____

IV. Please list or provide a list of any medications you are currently taking. Include any supplemen and/or any over the counter medications

Name	Dosage	Reason (heart, diabetes, pain, etc.

VI. How many packs of cigarettes do you currently smoke each day on average? Please choose only ON of the following:
not smoke O Less than 1 pack per day O More than 1 pack per day O

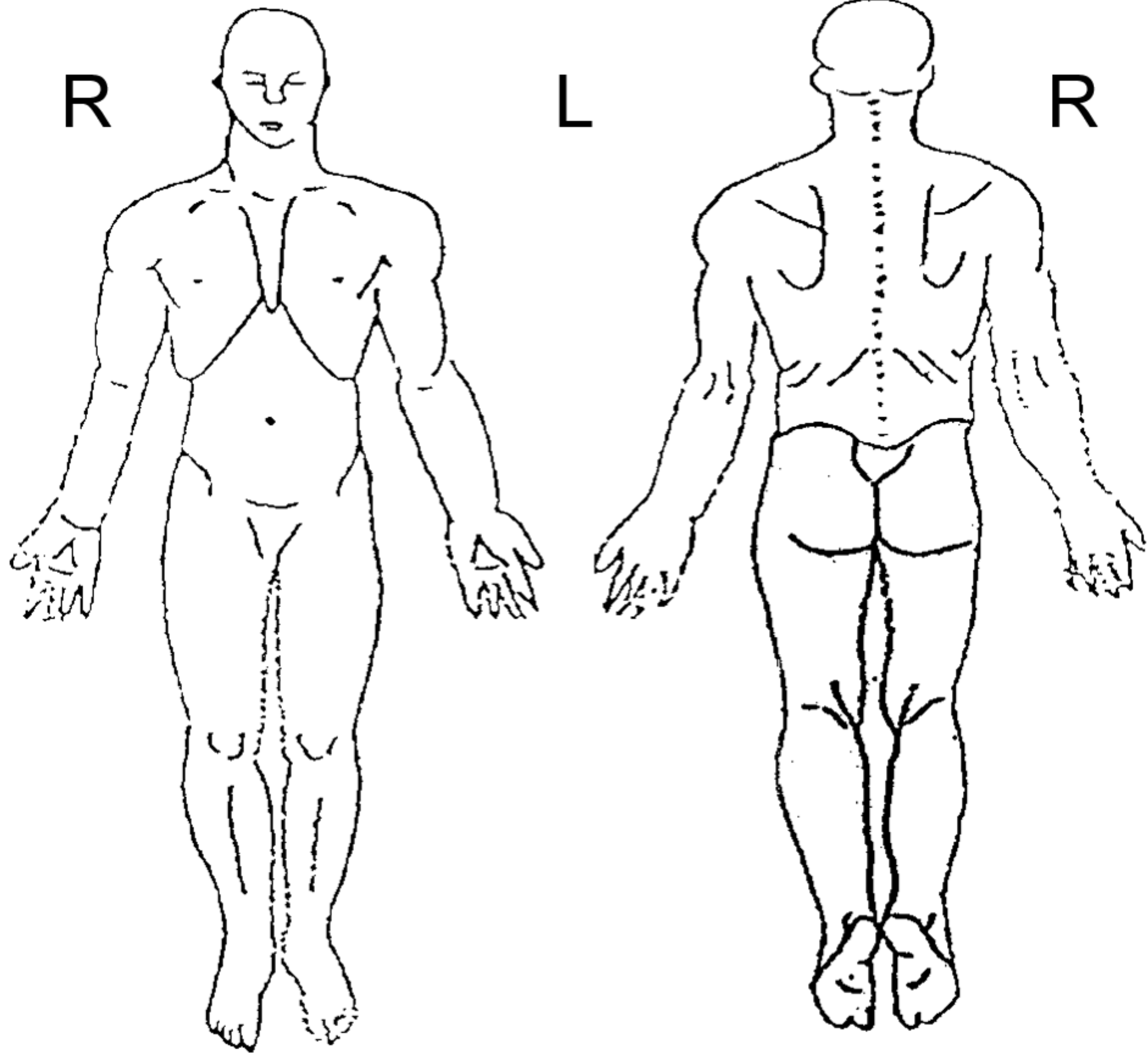
VII. How many cups of caffeinated beverage do you drink each day
1 cup of coffee equals 1 cup, 2 cups of tea equals 1 cup, 3 cans of soda equals 1 cup.
Please choose only ONE of the following answers
Do not drink caffeine O 1-2 Cups O 3 cups or more O

VIII. Do you have any allergies to Latex or Steroids? Latex : Yes O No O Steroids : Yes O No O

IX. Have you fallen in the past 12 months? Yes O No (

____ ________________________
Patient's signature (verifies that the above information is accurate) Date

Please indicate below where your symptoms are located by shading in the area(s)



Rate Your Pain

0 = No Pain
10 = Worst Pain Imaginable

	0	1	2	3	4	5	6	7	8	9	10
Right Now	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Worst in past week	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Best in past week	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Name ______________________ Date ______________________