Granite State Physical Therapy PLLC
Excellence in Rehabilitation Services

History of Your Current Injury

Name: _____ DOB: _____ Today's Date: _____

Date of onset of your present symptoms that we will be treating you for: _____

Please indicate how symptoms started *(ie fall, car accident , sports injury etc)* _____

_____

_____

Where are your present symptoms located? _____

Is your condition getting better, getting worse or staying the same? _____

Have you had any surgery for this condition? *(if yes, indicate date)* _____

For Worker's Comp Injuries:

Job Title: _____ Are you presently working? _____

Employer: _____ How many hrs /week do you normally work? _____

Are you working with any restrictions, if yes, what restriction? _____

Pain Scale: Please indicate your pain below based on the following scale.

0 1 2 3 4 5 6 7 8 9 10

No pain at all With any activity — Moderate pain with Half of my activities — Extreme pain with all activities

What is your pain at its worst? _____ What is it at it's best? _____ Pain on average? _____

Past Medical History

Have you or any of your family ever had any of the following: *(circle any that apply)*

Cancer	self	family	High Blood Pressure	self	family
Diabetes	self	family	Heart Disease	self	family
Angina/ Chest pain	self	family	Stroke	self	family
Arthritis	self	family			

Have you had a previous injury to the body part/ area we are treating you for currently? _____

Were your symptoms resolved after that injury or did you have remaining symptoms? _____

Your goal for treatment: