PHYSIOTHERAPY FORM

Name: ____

Age: ______________________ **Occupation:** _________________________________

Email: __________________________________

Physiotherapy treatment is voluntary and patient´s own responsibility. All the information will remain confidential and will not be shared with third parties.

Signature: _____________________ **Date:** ______________________

What is your major symptom/problem? ____

When did it begin? ____

How did it begin? ____

What makes it worse? ____

What makes it better? ____

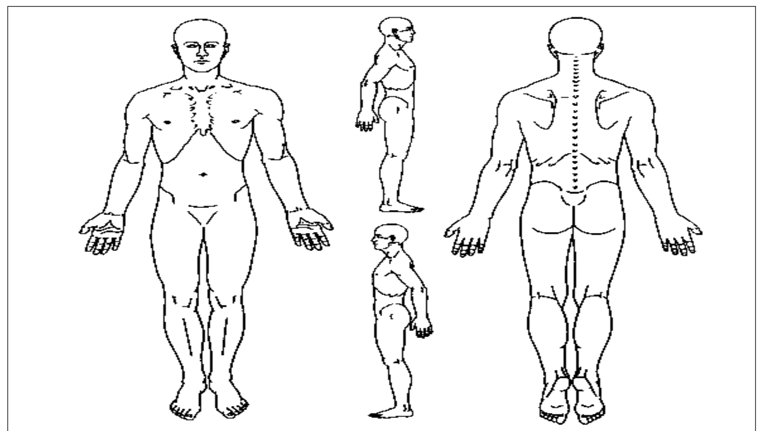
Are your symptoms/problems: ❑ improving ❑ worsening ❑ same?

Rate your pain/discomfort on a scale:

min → max

0	1	2	3	4	5	6	7	8	9	10

Mark the area of your symptoms:



Describe your pain:

❑ Sharp ❑ Burning

❑ Dull ❑ Throbbing

❑ Tingling ❑ Aching

❑ Other _____________________

Does it affect your: ❑ sleep ❑ everyday life ❑ work ❑ hobbies?

Any previous treatment? Results? ____

____

Have you had any similar symptoms/problems before? When? How often? ___________________

____

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Have you had any X-rays/ CAT-scan /MRI? ❑ Yes ❑ No

When? ____________________________

Medical history (check all that apply):

- ❑ Headache
- ❑ Ringing in the ears
- ❑ Loss of balance
- ❑ Dizziness
- ❑ Fainting
- ❑ Cold sweats
- ❑ Unexplained weight loss
- ❑ Night pain
- ❑ Fatigue
- ❑ Depression
- ❑ Neck pain/stiffness
- ❑ Back pain/stiffness
- ❑ Hip/leg pain
- ❑ Shoulder/arm pain
- ❑ Scoliosis
- ❑ Loss of strength in arms/legs
- ❑ Numbness or pins/needles in arms
- ❑ Numbness or pins/needles in legs
- ❑ Numbness in buttock/groin area
- ❑ Other________________
- ❑ Difficulty breathing
- ❑ Chest pain
- ❑ Heart disease
- ❑ Anaemia
- ❑ Diabetes
- ❑ Thyroid dysfunction
- ❑ Osteoporosis
- ❑ Incontinence/leakage
- ❑ Constipation/diarrhoea
- ❑ Diastasis (tummy gap)

PREGNANCY (if applicable)

Pregnancy week	Pregnancy due date	High-risk pregnancy (yes/no)

Do you smoke? ❑ No ❑ Yes. **How many per day?** ___________________________

Blood pressure: ❑ High ❑ Low ❑ Normal

Car accidents/traumas ____

Operations ____

Falls/broken bones ____

Current medications

❑ Blood pressure medication ❑ Thyroid medication ❑ Blood thinners ❑ Oral steroids

❑ Painkillers ❑ Antidepressants ❑ Other ____________________

Sports/hobbies: ____

How often? ____

What are your goals and expectations of physiotherapy? ___________________________________

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