ACE THERAPEUTIX
Patient-focused.
Personalized compassionate care.
Empowering outcomes.

10750 Rhode Island Ave. Beltsville, MD 20705
301.937.1632 | acetherapeutix.com

Patient Medical History

Name: _____ Date of Birth: _____/_____/_____ Age:_____

Is this injury related to an Auto Accident? ☐ Yes ☐ No

Did this injury happen while at Work? ☐ Yes ☐ No

Do you have a current Workers Compensation Claim Open? ☐ Yes ☐ No

I am: ☐ Male ☐ Female

I am living: ☐ Alone ☐ Alone but with assistance for my needs
☐ With an adult person(s) ☐ With children in home, ages_____

I am currently: ☐ Employed; my job is _____
☐ I am on a sick leave ☐ I am on disability ☐ Applying for disability
☐ I am unemployed ☐ I am retired ☐ I work inside the home

My physical activities include:
☐ Reading, watching TV
☐ Walking, gardening, housework, occasional physical exercise
☐ Regular physical exercise at least twice per week

I began having pain/symptoms on or about: _____/ _____/_____

I have had this condition: ☐ Never until now ☐ Once ☐ Many times before

What activities and/or activities make your pain worse? *(circle below)*

Sitting Standing Walking Bending Stairs Transfers Squatting Bending Kneeling Driving Lying Down
Reaching Overhead Reaching behind back Lifting Objects Dressing Cooking Cleaning Gripping objects
Other: _____

What eases your pain? *(circle below)*
Ice Heat Rest Stretching Therapy Medication Lying down Standing Sitting Bending
Other:
_____

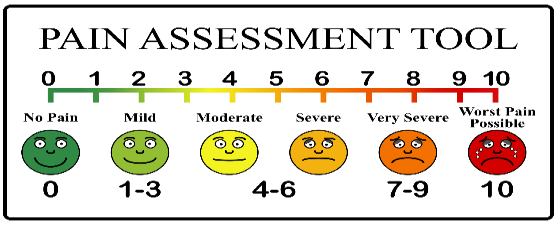
Have you had/or scheduled for diagnostic imaging *(i.e. X-ray, MRI, Nerve conduction study, etc.)?*
Explain:
_____

Are you able to perform any activities that you were not able to before starting physical therapy? ☐ Yes ☐ No
Explain:
_____

Have you ever had Physical Therapy before? ☐ Yes ☐ No

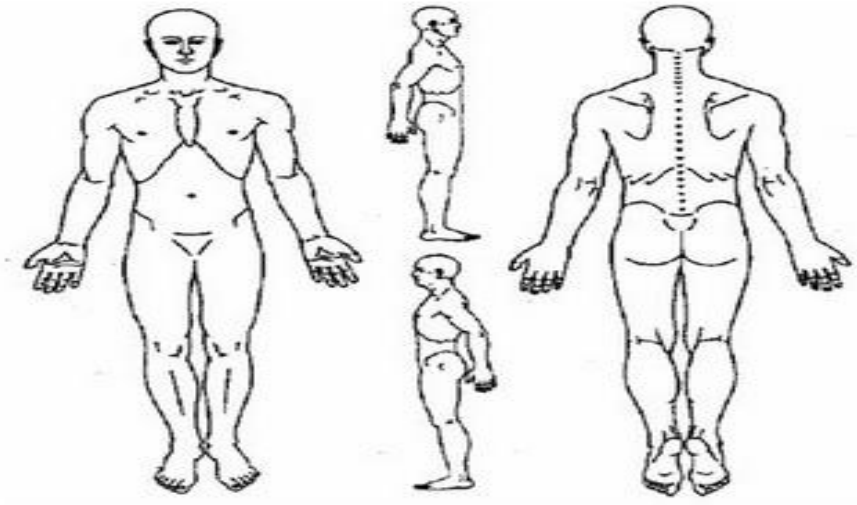
_____

Please rate your pain level using the tool provided:



At Worst: _____ /10
Current: _____ /10
Best: _____ /10

Please Mark the area of pain or discomfort on the chart provided, using the appropriate symbols:



Burning: ^ ^ ^ ^ ^
Sharp: + + + + +
Dull/Achy: X X X X X
Throbbing: : o o o o o
Shooting: → → →
Numbness/Tingling : =====

My Pain is: ☐ **Constant** ☐ **Intermittent**

Are you currently taking **any** Medication(s)?
☐ Yes ☐ No
List current medication(s) Please include Dose/Frequency (or provide list):
_____
_____
_____

Currently, I am experiencing the following *(check all that apply):*

☐	Unexplained Weight Loss	☐	Difficulty Swallowing	☐	Dizziness
☐	Increased Pain at Night	☐	Headaches	☐	Changes in Bowel/Bladder Function
☐	Fever / Chills / Sweats	☐	Nausea / Vomiting	☐	Depression
☐	Changes in Appetite	☐	Numbness / Tingling	☐	Shortness of Breath
☐	Difficulty Swallowing	☐	Muscular Dystrophy	☐	Other: _____

Have you fallen over the past 12 months? ☐ Yes ☐ No **If yes, how many times?** _____

Have you **ever** had any surgery? ☐ Yes ☐ No

Date of Surgery: _____/_____/_____

Type of Surgery: _____

Past Medical History: Do you now have/or have you ever had any of the following conditions? (***Circle all that apply***)

☐	Alzheimer's	☐	History of Cancer
☐	Cardiovascular Disease	☐	Huntington's
☐	Cauda Equina Syndrome	☐	Immunosuppresion
☐	Stroke	☐	Lupus
☐	Current Infection	☐	Muscular Dystrophy
☐	Diabetes type 1	☐	Obesity
☐	Diabetes type 2 (adult onset)	☐	Osteoarthritis
☐	Fibromyalgia	☐	Parkinson's
☐	Fracture or suspected fracture	☐	Rheumatoid Arthritis
☐	High Blood Pressure	☐	Traumatic Brain Injury
☐	Other :_____	☐	Pacemaker

During the past month, have you often been bothered by feeling down, depressed or hopeless? ☐ **Yes** ☐ **No**
During the past month, have you often been bothered by little interest or pleasure in doing things? ☐ **Yes** ☐ **No**

What activities are you having difficulty doing because of your pain or dysfunction?

_____

What is your personal goal for Physical Therapy?

_____

Is there any other information or concerns you would like to share with your therapist?

_____

Patient Name (Printed):_____ Date: ____/ ____/ _____

Patient/Guardian Signature: _____

To our patients: Although many of these questions may not seem relevant to your visit today, we ask that you communicate with us regarding symptoms or history you have, as this information can be of great assistance in determining whether therapy is indicated, and to what degree it may be of help. And even if your provider is aware of a symptom or illness, please let us know about it, and also if there has been any worsening of late. An important aspect of treating musculoskeletal injuries is screening for other conditions and factors that may play a role in your symptoms; this helps us to provide effective interventions, and to be advocates for your overall wellbeing and health.

For therapist use:

Self-reported or functional index score: _____/_____

Oswestry Cervical Index DASH LEFS DHI FOTO Other:_____

Therapist signature Date