Clark Arias Physical Therapy
275 W. Tietan St., Walla Walla - 522-0114

MEDICAL HISTORY

NAME _____ Prefer to be called _____ DATE _____ AGE _____

1. Have you ever had any of the following: YES NO (Circle below all conditions that apply)

Heart Disease	Angina	Cancer	Diabetes	High Blood Pressure
Blood Clots	Emphysema	Pacemaker	Asthma	Stroke
Epilepsy	Osteoporosis	Other (list):		

_____

Are you or might you be pregnant at this time? Yes No

Surgery (list): _____

_____

2. Medications taking: _____

_____

3. How long have you had the condition for which you were referred to our office? _____
4. What treatments have you had for this condition? _____

_____

5. Is there anything that makes this condition better? _____

_____

6. Is there anything that makes this condition worse? _____

_____

7. Affects on sleep: _____
8. What diagnostic tests have you had for this condition? Circle below the tests you have had:

X-RAYS CATSCAN MRI EMG

9. Please circle the one choice which most closely describes your pain right now:

0	1	2	3	4	5	6	7	8	9	10
No pain		Mild		Moderate		Severe		Very severe		Emergency

10. Using the above scale, rate your pain:
    Worst pain past month (0 to 10) _____
    Least pain past month (0 to 10) _____

11. Please indicate on the drawing at right where your pain is that we are treating today (if you have any):