Kristen Trahan Physical Therapy LLC
120 Cottage Street
Littleton, NH 03561
(603) 444-9865

Client History Form

Name:_____ DOB:_____

Address:_____ Home phone:_____
Work phone:_____
_____ Cell Phone:_____

If you are seeking treatment for a specific issue please answer the following:

When did your symptoms start? Date _____

Can you identify a cause for your symptoms? Yes_____ No _____ If yes, specify:_____
_____

Have you ever had similar symptoms in the past? Yes ____ No ____ If yes, when?_____
_____

Pain rating: Indicate your CURRENT level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10
No Pain Moderate Pain Worst Possible Pain

Describe your symptoms. Include the character of your pain (sharp, dull, achy, dizzy, etc.?)
_____
_____

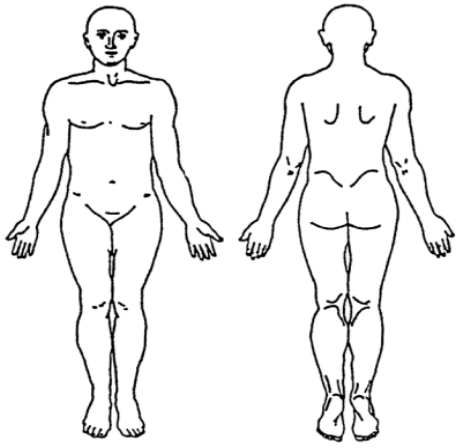
Does the pain move or radiate anywhere? Yes _____ No _____ If yes, please describe:
_____

Do you have numbness, tingling, or weakness? Yes _____ No _____ If yes, please describe:
_____

What activities/positions make your symptoms worse? _____
_____

What activities/positions make your symptoms better? _____
_____

Is your pain constant? Yes _____ No _____



Please use the body diagram and Shade Areas of Pain

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Past Medical History: Have you ever been told you have any of the following?

Cancer	Yes	No	Osteoarthritis	Yes	No
Heart problems	Yes	No	Depression	Yes	No
High Blood Pressure	Yes	No	Lung problems	Yes	No
Angina/Chest Pain	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Seizures/Epilepsy	Yes	No
Diabetes	Yes	No	Latex Allergy	Yes	No
Osteoporosis	Yes	No	Fibromyalgia	Yes	No
Rheumatoid arthritis	Yes	No	Kidney disease	Yes	No

Other _____

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss
Nausea/vomiting	Changes in appetite	Headaches
Shortness of breath	Night pain	Changes in bowel or bladder function

Past Medical History (Is there anything else that has not already been covered that may affect your care, i.e., heart attack, fractures, or surgical procedures?)

_____

_____

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for an errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform Kristen Trahan Physical Therapy LLC if I ever have a change in health.

_____ _____
Signature of Patient, Parent/Guardian Date

_____ _____
Please print name of Patient, Parent/Guardian Relationship to Patient