Patient Information & History

Cambridge Physio

Name:	**Date of injury**
AGE: **Today's Date:**	**Referred Physician:**
Job: Working Currently: Yes / No / Retired ☐ Normal job? ☐ Limited duty?	**Diagnosis** **(if you know or have been told)?**

Where is your problem? (please circle)

Shoulder Knee Elbow
Neck Back Other

Dominant Arm? Right / Left

Problem(s) (please check /circle all that apply):

- ☐ Pain?
- ☐ Weakness / Instability / giving way?
- ☐ Dizziness / Headache / Numbness?
- ☐ Stiffness / Fatigue?
- ☐ Swelling./ Deformity?
- ☐ Other

How long have you had symptoms?

Days Months Yrs

Current Medications (for):

How did you injure yourself?

- ☐ No injury – just started hurting
- ☐ Sports (which sport?)
- ☐ Motor vehicle accident
- ☐ Work / job –

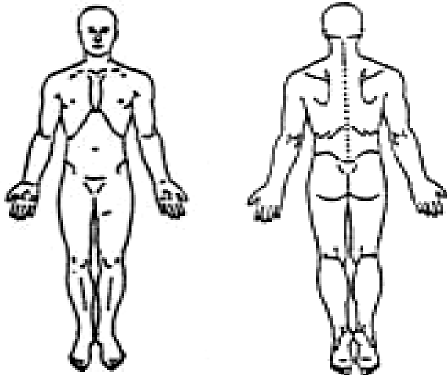
Is there a worker's comp claim? Yes / No

Please briefly describe the injury:

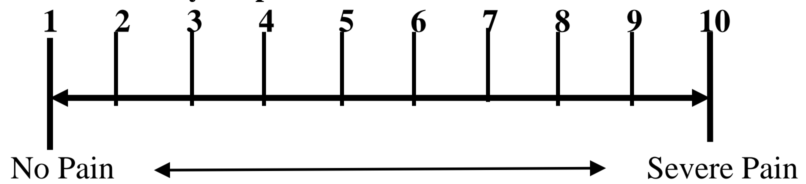
If involved in a motor vehicle accident:

You were: Driver Passenger Pedestrian
You were struck from Back Front Left side Right side
You were taken to a hospital? No / Yes
You were lost consciousness? No / Yes

Where is your pain?



How severe is your pain?



No Pain ⟵⟶ Severe Pain

Your Current Limitations:

Have you had any X-rays: No / Yes Date:
SCAN/MRI No / Yes Date:

Allergies?

Medical History: (please circle)

Do / did you have any heart problems? No / Yes
Do / did you have any Arthritis? No / Yes
Do / did you have diabetes? No / Yes
Do / did you have High Blood Pressure? No / Yes
Do / did you had any recent Surgery? No / Yes
Do / did you had any other fall/injury? No / Yes
Do / did you have cancer? No / Yes
Do / did you smoke? No / Yes

You live in: Apartment_ _ _House._ _ [Any stairs_ _ _ _]

You live: Alone_ _ _ Spouse and/or others_ _ _ _

Do you exercise regularly? _ _ _ Yes _ _ _No

Sports level: None / Recreational / College / Professional

Rate Your Health:

☐ **Good** ☐ **Fair** ☐ **Poor**

If you have any questions, complete the parts you can and ask us on your first visit. We can't wait to help you get better!