Physical Therapy Medical History

Medications:_____
_____

Surgeries:_____
_____

Please check all that apply:

Pacemaker	Yes	☐	No	☐
Pregnant	Yes	☐	No	☐
Cancer	Yes	☐	No	☐
Diabetes	Yes	☐	No	☐

Area of Pain:_____

Pain Level (please select one, 0-lowest 10-highest)

0	1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○	○

Patient Name:_____ **Date**:_____

Outcome Survey Activities of Daily Living Scale

Name: _____ Date: _____

Directions: To what degree does each of the following symptoms affect your level of daily activity? (place a check in the corresponding column)

	Never Have	Have, but does not affect activity	Affects activity slightly	Affects activity moderately	Affects activity severely	Prevent me from all daily activity
	5	4	3	2	1	0
Pain	☐	☐	☐	☐	☐	☐
Grinding of Grating	☐	☐	☐	☐	☐	☐
Stiffness	☐	☐	☐	☐	☐	☐
Swelling	☐	☐	☐	☐	☐	☐
Slipping or partial giving way of knee	☐	☐	☐	☐	☐	☐
Buckling or full giving way of knee	☐	☐	☐	☐	☐	☐
Weakness	☐	☐	☐	☐	☐	☐
Limping	☐	☐	☐	☐	☐	☐

Directions: How does your knee affect your ability to… (place a check in the corresponding column)

	Never Have	Have, but does not affect activity	Affects activity slightly	Affects activity moderately	Affects activity severely	Prevent me from all daily activity
	5	4	3	2	1	0
Walk	☐	☐	☐	☐	☐	☐
Go up stairs	☐	☐	☐	☐	☐	☐
Go down stairs	☐	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐	☐
Kneel on the front of your knee	☐	☐	☐	☐	☐	☐
Squat	☐	☐	☐	☐	☐	☐
Sit with your knee bent	☐	☐	☐	☐	☐	☐
Rise from a chair	☐	☐	☐	☐	☐	☐

Office Use Only: Score: _____/80 points (MDC 8.4) Number of PT Sessions: ____ Gender: M F Age: ____

ICD-9 Code: _____

NOTICE TO ALL PATIENTS

This office calls insurance companies to verify coverage and benefits as a courtesy to our patients. It is ultimately the patient's responsibility to know their own deductible and co-payments for medical services.

All co-payments are due at the time service is rendered.

Any charges that the insurance company does not cover will be the responsibility of the patient.

Thank you!

Patient signature:_____

Date:_____