Midland Physical Therapy Sports Rehab **Patient Name: _____**

Patient History

Please list all previous treatments for this condition:

Name of Treating Physician: _____ Date of Treatment: _____

Type of Treatment or Drugs Prescribed:

Please list all past surgeries:

Type: _____ Date of Surgery: _____ Doctor: _____

Type: _____ Date of Surgery: _____ Doctor: _____

Please list all previous accidents and falls:

What: _____ Date: _____

What: _____ Date: _____

Patient Signature: _____ Date: _____

Please do not write below this line

Doctors Notes:

Pain Level:	
Worst:	/10
Current:	/10
Best:	/10

History:_____

_____

_____

Objective Findings:_____

_____

_____

ROM:_____Strength: _____

Special Tests:_____

Patient Goals:

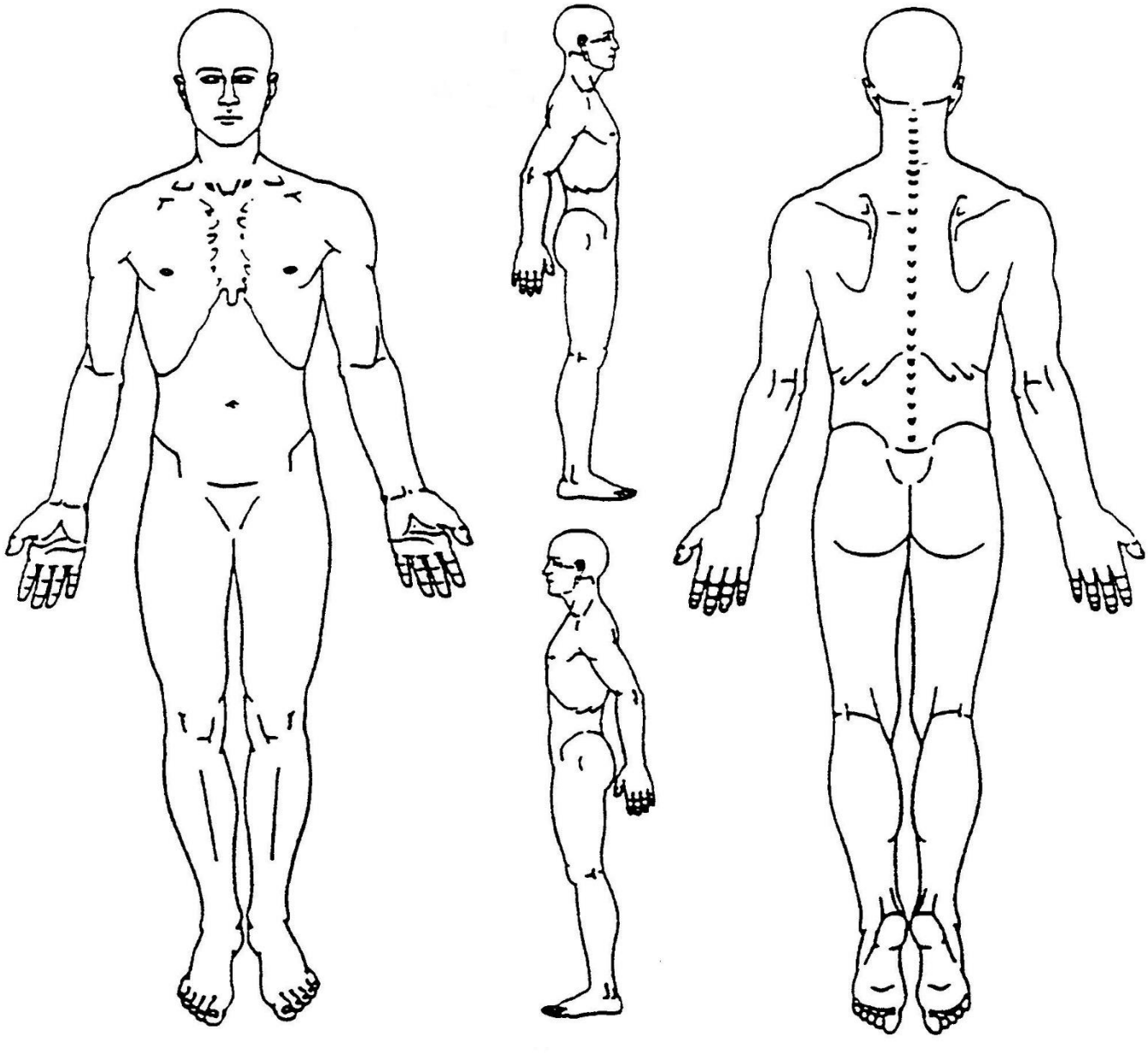
_____

_____

_____

_____

Midland Physical Therapy Sports Rehab **Patient Name: _____**



Legend:

X - Numbness or Tingling

/ - Sharp or Shooting

◯ - Aching or Dull