MADDEN PHYSICAL THERAPY

MEDICAL HISTORY

Patient Name: _____ **Date:** _____

Medical History: Are you currently experiencing or have you had any of the following:

High Blood Pressure	Y N	Heart Disease	Y N	Numbness	Y N
Bowel/Bladder Problems	Y N	Pacemaker	Y N	Cancer	Y N
Shortness of Breath	Y N	Weakness	Y N	Pregnant	Y N
Female Problems	Y N	Diabetes	Y N	Dizziness	Y N
Night Pain	Y N	Fatigue	Y N	Osteoporosis	Y N
Irregular Heart Rate	Y N	Headaches	Y N	Stroke	Y N

Surgeries? Y N (List) _____

How would you rate your general health? (circle one) Poor Fair Good Excellent

In the past 3 months, have you experienced any significant changes in health (physical or mental) such as unexplained weight loss, depression, nausea, etc? (List)_____

List other medical problems: _____

Currently:

What is your current complaint? _____ When did it start? _____

Due to an injury? Y N (Explain) _____ Illness? _____

Did the symptoms begin: Suddenly or Gradually Previous problems in this area? Y N

Previous therapy for this condition? Y N What effect? _____

Have you had chiropractic or any other treatment for condition? Y N

Are you getting: Better Same Worse Are you better with rest? Y N

Does activity make you worse? Y N Which activities? _____

Are you worse in the: Morning Afternoon Evening Is your pain: Continuous Occasional

Does your pain radiate? Y N Where? _____

What reduces your pain? _____

What can't you do because of your symptoms? _____

Recent tests: X-ray CT MRI EMG Myelogram Other _____

Results: _____

What did the Doctor tell you is your diagnosis? _____

Did the physician put you on any restrictions? Y N List: _____

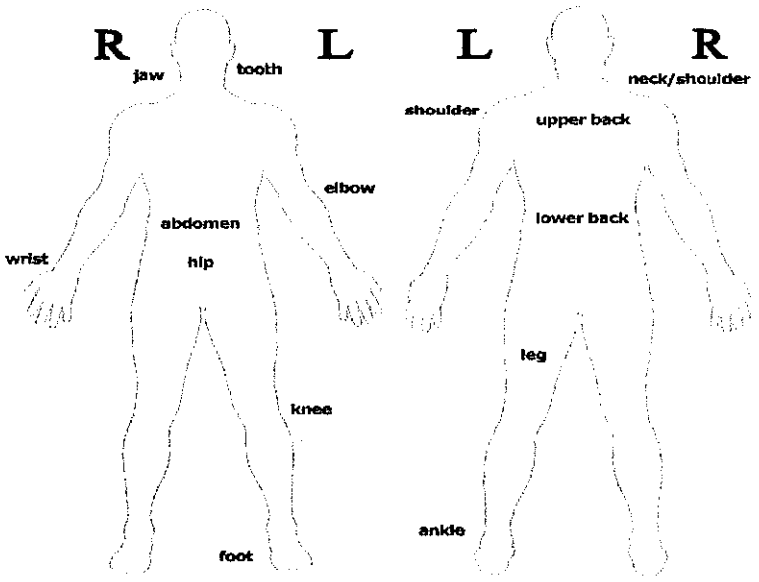
Are you currently employed? Y N What are your job tasks? _____

Based upon a 0 to 10 scale (0 is none and 10 is severe), what is your pain:

Right now: _____ Highest pain in past 24 hours: _____ Lowest pain in past 24 hours: _____

PLEASE COLOR YOUR AREA OF PAIN ON THE BODY DIAGRAM BELOW

FRONT



BACK

MADDEN PHYSICAL THERAPY

Knee, Ankle, Foot Questionnaire

Lower Extremity Functional Scale

Patient Name: _____ D.O.B._____ Date: _____

Activities Please rate the difficulty levels below by the way you are feeling today.	**Extreme Or unable to perform Activity**	**Quite a bit of difficulty**	**Moderate difficulty**	**A little bit of difficulty**	**No difficult**
Any of your usual work, housework, or school activities.	**0**	**1**	**2**	**3**	**4**
Your usual hobbies, recreational or sporting activities.	**0**	**1**	**2**	**3**	**4**
Getting into or out of the bath.	**0**	**1**	**2**	**3**	**4**
Walking between rooms.	**0**	**1**	**2**	**3**	**4**
Putting on your shoes or socks.	**0**	**1**	**2**	**3**	**4**
Squatting.	**0**	**1**	**2**	**3**	**4**
Lifting an object, like a bag of groceries from the floor.	**0**	**1**	**2**	**3**	**4**
Performing **light** activities around your home.	**0**	**1**	**2**	**3**	**4**
Performing **heavy** activities around your home.	**0**	**1**	**2**	**3**	**4**
Getting into or out of a car.	**0**	**1**	**2**	**3**	**4**
Walking 2 blocks.	**0**	**1**	**2**	**3**	**4**
Walking a mile.	**0**	**1**	**2**	**3**	**4**
Going up or down 10 stairs (about 1 flight of stairs)	**0**	**1**	**2**	**3**	**4**
Standing for 1 hour.	**0**	**1**	**2**	**3**	**4**
Sitting for 1 hour.	**0**	**1**	**2**	**3**	**4**
Running on even ground.	**0**	**1**	**2**	**3**	**4**
Running on uneven ground.	**0**	**1**	**2**	**3**	**4**
Making sharp turns while running fast.	**0**	**1**	**2**	**3**	**4**
Hopping.	**0**	**1**	**2**	**3**	**4**
Rolling over in bed.	**0**	**1**	**2**	**3**	**4**
Column Totals:					

SCORE: _____ /80