Integrated Physical Therapy

PATIENT MEDICAL SUMMARY SHEET

To assist us in providing the best possible care, please fill out the following information about your current medical conditions, medications, operative history, drug allergies, and pain.

Name_____ Date_____

Medical Conditions **Current Medications**

Condition	Date	Drug and Dose	Start Date	End Date
Are you pregnant?				

Significant Operations and Invasive Procedures

Procedure/Operation	Date	Procedure/Operation	Date

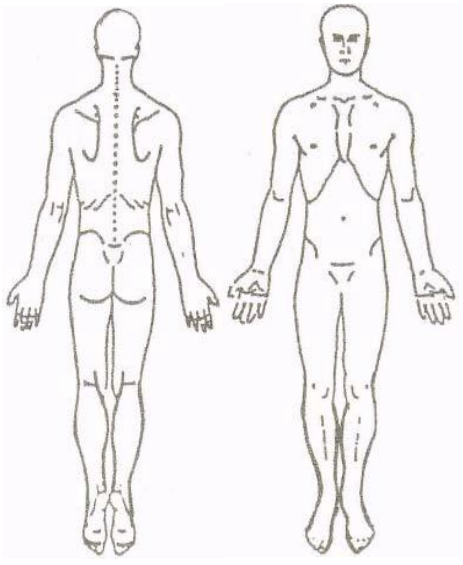
Drug Allergies/Reactions

Drug/Reaction	Date	Drug/Reaction	Date

Pain Evaluation: Please rate the pain that you have experienced in the last 30 days according to the 0 – 10 scale on the right.

Pain: Currently:_____ Max:_____ Min:_____ 0----1----2----3----4----5----6----7----8----9----10

No Pain Strong Max



Pain Drawing: Mark the diagram on the left according to where you are having pain (if the back of your neck hurts, mark the drawing at the back of the neck, etc.) If you feel any symptoms identified in the key, please indicate where you feel them ny placing the marks shown in the key at the appropriate places on the diagram.

KEY:

Stabbing	**Burning**	**Pins and needles**
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Numbness	**Aching**	
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