Lené van der Linde
PHYSIOTHERAPY
www.lenephysio.co.za

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PATIENT DOCUMENTATION

Date:

Name: Surname:	Age: Medical diagnosis: *(If applicable)*
Occupation: Hobbies, sport: *(activity level)*	Source of referral: Dominance: *(hand/leg)*

CURRENT HISTORY
Main complaint (e.g. neck pain):
Date of injury or onset of current symptoms:
Describe your pain: Dull / Sharp / Shooting / Stabbing / Burning / Throbbing / Pins and Needles / Ache / Tight feeling
How often do you experience this pain? (Constantly every day / Intermittently through the day / Not every day)
IF intermittent, specify: ___ times a day/week/month AND How long does the pain last? ___ minutes/hours AND
Is the pain related to an activity or a position?
Is your pain deep or superficial?
Rate your pain out of 10: ___ /10 (at its worst) ___ /10 (at its best)
What makes your pain worse: Standing / sitting / bending / lying down / walking / sustained positions / repetitive movements / sport / stress / other
What makes your pain better: Standing / sitting / bending / lying down / walking / resting / medication / None of the above / Other
When is your pain the worst: Morning / During the day / Evening / Constant
Does your pain wake you up at night: Y / N If so, about what time usually? ___ pm / am
Do you have significant pain or stiffness when you wake up: Y / N If so, how long does it last? ___ minutes / hours
Have you had this problem before? (if so, when?)
Have you had previous treatment for this complaint? (If so, did it bring relief? Please describe shortly)

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Does the pain/complaint influence your daily life or work routine? Y / N
Are you improving / worsening / staying the same
What worries you the most about your condition?
Have you had any diagnostic tests such as an X-Ray, MRI, CT-Scan or other for this problem? If so please date and indicate
Please list any medications you are currently taking. Have you ever been on cortisone? Y / N

GENERAL HEALTH

SURGERY / HOSPITALIZATION / SERIOUS ILLNESS	
Year	Please Describe

ACCIDENTS (E.G HORSERIDING ACCIDENTS, MOTOR VEHICLE ACCIDENTS, WHIPLASH)	
Year	Please Describe

HAVE YOU PREVIOUSLY BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?							
Heart Problems		Epilepsy / Seizures		HIV / Aids		Vision or hearing problems	
High blood pressure		Stroke		Tuberculosis		Pacemaker	
Diabetes		Thyroid Disease		Lower back problems		Metal Implants	
Arthritis		Blood clot / Emboli		Neck problems		Osteoporosis	
Osteoporosis		Hepatitis		Migraine Headache		Rheumatoid Arthritis	
Cancer		Asthma		IBS		Osteoarthritis	
Other:						Do you smoke?	Y/N

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SPECIAL QUESTIONS

HAVE YOU RECENTLY NOTED:					
Unexplained weight loss		Nausea or vomiting		Dizziness / light-headedness	
Fatigue/tiredness		Weakness		Fever / chills / sweats	
Bowel or bladder irregularities		Numbness / Tingling /Pins and needles		Decreased sensation of buttocks area	
Balance disturbances		Change in walking pattern		Visual disturbances	

OTHER:			
Desrcibe your mattress:	Firm	Soft	____ years old
Describe your pillow:	High	Low	2 Pillows
What is your normal sleeping position?	On your back	On your side	On your tummy
If you work at a desk:			
Are you aware of what a good set-up is?	Y	N	
Do you need advice to improve your set-up?	Y	N	
For lower limb complaints:			
Do you have orthotic innersoles?	Y	N	
Describe the shoes you normally wear:	Slops/sandals	Closed shoes	Running shoes/Sneakers
	Shoes with heels	Other:	
Describe your running shoes (if applicable)	Pronation control	Neutral	Other:
How old are your running shoes:			