McCall Method

McCall Method | 61548 West Ridge Ave. | Bend, OR 97702
Lisa Ann McCall P.T. | 214-957-0234

PATIENT/CLIENT HISTORY FORM

Name_____ Date of Birth_____

Age_____ Height_____ Weight_____ Sex: Male/Female Handedness: Right/Left

Occupation_____

Are you currently off work because of this problem? ☐ Yes ☐ No ☐ Light duty

Diagnosis_____ Referral Source_____

When did your problems begin?_____

How did your problems begin?_____

_____

_____

Rate your pain: *(please circle one)*
No Pain | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | Worst Pain

Draw your pain:

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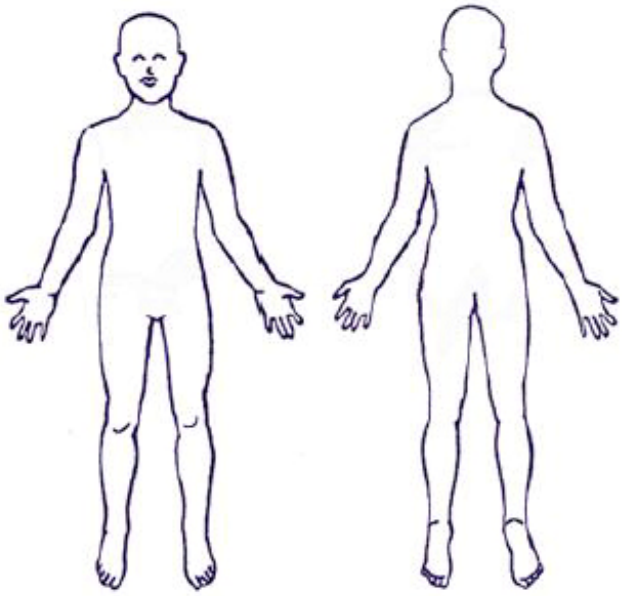

Describe your pain: *(circle any that apply)*

Dull | Ache | Sharp | Stabbing | Pins & Needles | Shooting Pain | Burning | Throbbing | Twinge | Numbness/Tingling
Other:_____

Is your pain constant? Yes | No Intermittent? Yes | No

Fluctuates with activity? Yes | No Wakes you up at night? Yes | No

What makes your symptoms worse? *(circle any that apply)*
Sitting | Standing | Walking | Lifting | Bending | Lying down | Squatting | Stress
Other:_____

Are you ever totally pain free? Yes | No

What makes your symptoms better? *(circle any that apply)*
Sitting | Standing | Walking | Lifting | Bending | Lying down
Other: _____

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What time of day are your symptoms worst? _____ Best?_____

Do you feel you are: Getting Better | Getting Worse | Staying the Same

Have you had this problem before? Yes | No

If yes, when and how did it get better? _____
_____

Any previous or current treatment for your current condition? Yes | No
If Yes, Please describe:
_____
_____
_____

Have you had diagnostic done for your current condition? (xrays,MRI,CT…?) Yes | No

Any other orthopedic problems? Yes | No
If yes, please explain:_____
_____
_____

Any medical problems? Yes | No
If yes, please explain:_____

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Any surgeries? Yes | No
If yes, please explain:

_____
_____
_____
_____

Please list **ALL** medications you are currently taking such as prescription and over-the-counter for this and any other condition:

_____
_____
_____
_____
_____
_____
_____
_____

Have you ever had a history of any of the following? *(circle any that apply)*

Major injury to head/spine | Cancer/tumors | Osteoporosis | Dizziness/blackouts |

Heart problems/angina | Diabetes | Pacemaker | Sudden weight loss/gain | Severe pain at night |

Smoking | Bruising easily | Asthma | Frequent falls | Loss of bowel/bladder control | Numbness |

Seizures/epilepsy | High blood pressure | Coordination loss

Does your current condition limit you in carrying out job duties? Yes | No
Household duties? Yes | No

What are your goals in physical therapy?

_____
_____
_____

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Thanks for taking the time to fill out this form as completely as possible! It will save us on treatment time during your first visit and will help in assessing your condition and guiding your treatment plan.

_____ _____

Patient or guardian signature Date