ATHENS PHYSICAL THERAPY
ATHENS NEURO AND BALANCE REHABILITATION
PHYSICIANS BACK AND NECK CLINIC
BETTER BONE CLINIC
CHRISTOPHER E. DOERR, D.O., P.C.

ORTHOPEDIC MEDICAL HISTORY

Patient Name____DOB________________

CURRENT CONDITIONS/CHIEF COMPLAINT(S):

1. What is the main problem/reason for your visit today?____
2. When did the problem(s) begin?____
3. What happened?____
4. Have you had this problem before? **YES/NO** If YES, how long did the problem last?___________________
5. What did you do for the problem(s)?____
6. Did the problem(s) get better? **YES/NO**
7. How are you taking care of the problem(s) now?____
8. What are your goals for physical therapy?____
9. Are you seeing any healthcare providers for your current problem(s)? **YES/NO**

   Please list:____
10. What are your symptoms?____
11. What makes your symptoms worse?____
12. What makes your symptoms better?____

***My signature below confirms that the information provided on this document is accurate to the best of my knowledge*.**

Patient Signature: ____ Date: _________

Parent/Guardian's Signature: ____ Date: _________