MEDICAL HISTORY FORM

Please complete this form as accurately as possible. It will assist us in providing you with a more thorough evaluation and in developing your plan of care. If you do not understand the question indicate that it with a question mark or ask the therapist for assistance.

Name: _____ Occupation: _____

Family Physician:_____ Referring Physician (if different)_____

Please describe the type of injury/condition/concern that brought you to our clinic today: _____

_____

_____

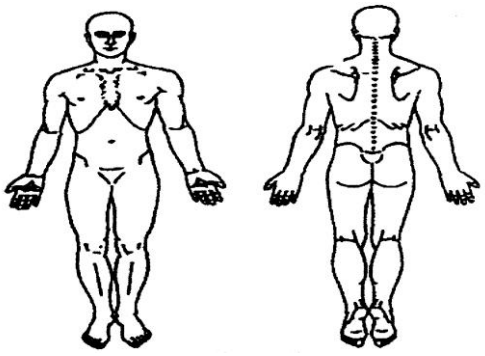
Briefly describe any previous treatments or surgeries for this condition: _____

_____

_____

How would you describe your symptoms: _____

_____



Please mark the area(s) of concern

Please rate your pain (0 =no pain, 1 = minimal, 10 = severe)

Currently	0	1	2	3	4	5	6	7	8	9	10
At its worst	0	1	2	3	4	5	6	7	8	9	10
At its best	0	1	2	3	4	5	6	7	8	9	10

Please Indicate any health care providers you are treating with and/or tests you have undergone **for this condition** in the past 6 months.

□ Family Physician	□ Dentist	□ Emergency Room	□ EMG/NCV
□ Orthopedist	□ Podiatrist	□ Xrays	□ Doppler
□ Neurologist	□ Chiropractor	□ MRI	□ Other
□ PhysicalTherapist	□ Psychiatrist	□ CT Scan	□ _____

Please list any **prescription and OTC medications** your are currently taking and the reason you are taking them:

Medication	Dosage	Frequency	Route (if other than pill form)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please briefly describe any surgeries, hospitalizations or significant injuries and the approximate dates:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

For clinic use

Do you now have or have you ever had any of the following conditions?

YES	NO	Pacemaker	YES	NO	Cancer _____
YES	NO	Shortness of breath / Chest Pain	YES	NO	Bowel or bladder problems
YES	NO	Heart Problems _____	YES	NO	Kidney problems
YES	NO	High blood pressure	YES	NO	Liver/Gallbladder problems
YES	NO	Stroke / TIA	YES	NO	Infectious diseases _____
YES	NO	Circulation problems/ blood clots	YES	NO	Arthritis/ Rheumatoid arthrits
YES	NO	Lung problems	YES	NO	Osteoporosis
YES	NO	Asthma	YES	NO	Metal implants_____
YES	NO	Diabetes	YES	NO	Dizziness / fainting
YES	NO	Seizures/Epilepsy	YES	NO	Severe/unusual headache
YES	NO	Thyroid problems	YES	NO	Depression
YES	NO	Indigestion/stomach ulcers	YES	NO	Other _____
YES	NO	Allergies/skin sensitivity _____	YES	NO	Other _____

During the past month have you been feeling down, depressed or hopeless? YES NO
During the past month have you been bothered by having little interest or pleasure in doing things? YES NO
Do you ever feel unsafe at home or has anyone tried to hit you or injure you in any way? YES NO

How many caffeinated beverages do you consume per day? _____
Do you now or have you ever smoked? YES NO If "YES", How many packs per day? _____ If you quit, when _____
How many days per week do you drink alcohol? _____ If so, how many drinks in an average sitting? _____

Has anyone in your immediate family (parents/siblings) been diagnosed/treated for any of the following?

YES	NO	Diabetes
YES	NO	Heart disease
YES	NO	High blood pressure
YES	NO	Stroke
YES	NO	Inflammatory arthritis
YES	NO	Depression
YES	NO	Alcoholism (chem. Dependency)
YES	NO	Kidney disease
YES	NO	Cancer

For clinic use

Have you recently noted any of the following:

YES	NO	weight loss / gain
YES	NO	nausea/vomiting
YES	NO	dizziness/lightheadedness
YES	NO	fatigue
YES	NO	weakness
YES	NO	fever/chills/sweats
YES	NO	numbness/tingling

Is there anything else that you would like to include or ask your therapist? _____
_____

What do you hope to accomplish with your treatment? _____
_____

How did you decide on our clinic for your physical therapy care?
□ Doctor recommended □ Friend/family □ Internet
□ Former Patient □ Insurance □ Other _____

Patient/Guardian Signature _____ Date_____ Therapist