Patient Medical History

Name: _____ Age: _____ Height: ____ft./____in. Weight: _____lbs.
Next Dr's appt: ___/___/___Referring Physician: _____ Doctor's Diagnosis:
_____
Your main concern: _____
Are you presently working? ____Yes ____NO What is/was your Occupation? _____
Employer: _____ Phone:
_____
Was your injury a result of an automobile accident? _____YES _____NO
Is the injury work related? _____ YES _____ NO **Date of Injury** _____/_____/_____
Is there an attorney involved? _____ YES _____NO
**** Are you currently having Home Health or had Home Health this calendar year? _____**
Who is your Primary Care Physician: _____When did you last see him/her? _____
Please check any of the following whose care you are under: __ Physical Therapist __ Chiropractor __Psychiatrist/Psychologist __Medical Doctor/Osteopath Other:_____
Have you, for any reason had out patient physical therapy this calendar year? Yes ___ or No ___ . If Yes— approximately how many visits? _____
Have you had any of the following tests for THIS condition? (If yes, please list date): X-rays_____, MRI _____, CAT scan _____, Bone Scan _____, Nerve/Muscle test _____, Other _____
Please list any surgeries (in/out patient) and any conditions for which you have been hospitalized and the dates:
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
During the past month have you been feeling down, depressed or felt hopeless? __Yes __No
During the last month have you been bothered by having little interest or pleasure in doing things? __Yes __No
Are you currently being treated by a physician for any heart related disorder? ___ Yes ____No If so, what was the diagnosis? _____
Are you a current smoker: ___Yes___No How many days per week do you drink alcohol? _____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____
Have you had a fall in the last year? ___Yes ___No If so, approx. how many falls have you had in the last year?
___
If you had a fall in the last year, was an injury sustained? ___Yes ___No If yes, please describe:_____

If you had a fall in the last year, do you currently take Vitamin D supplements? _____YES _____NO
Therapists:--If screen indicates potential fall risk please include in your exam components looking at balance, strength, and gait training/ instructions, etc.

Women: Are you currently pregnant or think you might be pregnant? _____YES _____NO

Which of the Over-the-Counter medicines have you taken in the last week? Please Circle those that apply.

Aspirin	Tylenol	Advil/Motrin/Ibuprofen
Antihistamines	Antacid	Vitamins/Mineral Supplements
Laxatives	Decongestants	Herbals--Please Specify_____

Please list any PRESCRIPTION medications, dosages, and frequency you are taking (including pills, injections, and/or patches):
1._____ ____ mg____/day 2. _____ ____ mg____/day 3._____ ____ mg____/day
4._____ ____ mg____/day 5. _____ ____ mg____/day 6._____ ____ mg____/day

Have you EVER been diagnosed as having any of the following conditions? Please circle those that apply.

Seizures/Epilepsy	Cancer	Diabetes	Vision/Hearing Problems	Headaches
Osteoporosis	Stroke/TIAs	High Blood Pressure	Heart Problems	Pacemaker

Rheumatoid Arthritis	Hepatitis	Anemia	Tuberculosis	Alzheimer's
Circulation Problems	Sleeping Problems	Depression	Weight/Energy Loss	Asthma
Emphysema/Bronchitis	Parkinson's	Chemical Dependency	Thyroid Problems	Multiple Sclerosis
Gout	Dehydration	Orthopedic Surgery	Urinary/Fecal Incontinence	Other _____

Have you recently noted?:

Weight loss/gain	**YES**	**NO**	**Weakness**	**YES**	**NO**
Nausea/Vomiting	**YES**	**NO**	**Fever/chills/sweats**	**YES**	**NO**
Dizziness/Lightheadedness	**YES**	**NO**	**Numbness or Tingling**	**YES**	**NO**
Fatigue	**YES**	**NO**	**Night Pain**	**YES**	**NO**

Please indicate your goals for physical therapy: _____

_____

Pain Scale-Please rank your pain on this 0-10 scale. Zero is pain free, 10 is the worst pain.

0 No Pain	1	2	3	4	5	6	7	8	9	10 Worst Pain

What aggravates your pain? ▫ Sitting ▫ Rise from sit ▫ Standing ▫ Lying Down ▫ Overhead Activity

▫ Lifting ▫ Bending ▫ Walking ▫ Running ▫ Stairs ▫ Squatting ▫ Dressing ▫ Stress

▫ Cough/Sneeze ▫Turning Head ▫ Driving ▫ Looking Up/Down ▫ Other_____

What eases your pain? ▫ Rest ▫ Ice ▫ Heat ▫ Changing positions ▫ Medications

▫ Other_____

Please draw in your complaint using the diagram and markings. Also draw other pain areas that you have at this time.

Ache	**Burning**	**Pins and Needles**	**Throbbing**	**Other/General Pain**
^^^^^^^^	**========**	**oooooooooo**	**////////////////**	**XXXXXXX**
^^^^^^^^	**========**	**oooooooooo**	**////////////////**	**XXXXXXX**

I do hereby state that the above information is accurate and true to the best of my knowledge.

_____ ___/___/___

Signature of Patient or Guardian Date

(If other than patient, please list relationship)

For Therapist Use Only

Reviewed by Therapist: _____ Date:_____