MEDICAL HISTORY

Patient Name:_____ Age:_____Today's Date:_____

Referring Physician:_____ Date last seen:_____

Is this job related?:_____ Auto accident?_____ What State? _____ Date of Injury:_____

Please describe current problem:_____

Have you had a similar problem before?_____ Please describe:_____

_____

Have you had physical therapy in the past?_____

What are your goals regarding physical therapy intervention?(Usually, pain relief is involved, but try to make the goals functional) _____

_____

Have you had any of the following tests for this condition:

	Date of test	Where were these tests taken
X-Ray		
CT Scan		
EMG		
MRI		
Other		

Pain aggravation (movements, positions, activities, etc):_____

_____

Pain relief:_____

Any limitations in daily living activities?_____

Do you now or have you ever had problems with any of the following:

☐ Pacemaker ☐ Osteoporosis ☐ High Blood Pressure ☐ Cancer

☐ Heart Problems ☐ Diabetes ☐ Pregnancy ☐ Other_____

☐ Metal Implants ☐ Lung Condition ☐ Deep Brain Stimulator (Parkinson's treatment) _____

☐ Spinal Fusion ☐ Neuropathy

Please list all medications you are currently taking: (attached separate sheet if necessary)_____

_____

Please list all past surgeries and dates:_____

_____

Please list any other care providers you have seen in the past 5 years:

1. _____ Reason:_____ Date last seen:_____

2. _____ Reason:_____ Date last seen:_____

Please turn this page over, it is a 2 page document, and complete the back...

Please check the appropriate box if any of the following pertains:

- ☐ Fever/chills/sweats
- ☐ Unexplained weight change
- ☐ Nausea/vomiting
- ☐ Change in appetite
- ☐ Painful/difficult breathing
- ☐ Dizziness/lightheadedness/fainting
- ☐ Change in energy level
- ☐ Swelling in legs - one or both
- ☐ Bowel dysfunction or change in stool color...explain _____
- ☐ Painful/difficult/frequent urination/blood in urine
- ☐ Change in sleep quality or position...explain _____
- ☐ Night pain
- ☐ Smoking: packs per day _____
- ☐ Alcohol consumption: drinks per day _____
- ☐ Family members with diabetes, heart problems, osteoporosis, etc...explain _____

_____

I certify that, to the best of my knowledge, the above and previous page statements are true.

_____ _____

Patient or Guardian Signature Date