



# MEDICAL HISTORY

Date \_\_\_\_\_ Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Condition \_\_\_\_\_

What are the symptoms: Pain Numbness Tingling Weakness Loss of Motion Nausea Other \_\_\_\_\_

When did this symptoms begin? \_\_\_\_\_

Where you Injured? Yes No Date of Injury \_\_\_\_\_

Briefly describe how the injury or condition occurred \_\_\_\_\_

Where you hospitalized from this injury? Yes No Where? \_\_\_\_\_ When? \_\_\_\_\_

Did you have surgery? Yes No Procedure \_\_\_\_\_ When? \_\_\_\_\_

Have you had this condition before? Yes No

How where you treated for it? No Treatment Medical Doctor Chiropractor Medication Other \_\_\_\_\_

Have you received Physical Therapy for this condition or any other condition before? Yes No

If yes, please list the date, clinic and condition \_\_\_\_\_

Have you received physical therapy treatment this year? Yes No

Have you received speech therapy treatment this year? Yes No

Have you received Home Health Care via Medicare this year? Yes No

### Have you had any imaging performed:

- X-Ray  MRI  CT Scan  EMG / NCV  Bone Scan

### Have you recently noted:

- Change in Vision or Hearing  Fever / Chills / Sweats  Pain at Night
- Cramps in Legs when Walking  Headaches  Pregnant / IUD
- Depression  Nausea / Vomiting  Stress
- Dizziness / Fainting  Numbness / Tingling  Weakness
- Fatigue  Insomnia  Weight Loss / Gain

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

- Anemia  Depression  Indigestion / Heartburn  Osteoporosis / Osteopenia
- Allergies / Skin Sensitivity  Diabetes  Kidney Problem  Parkinson's Disease
- Asthma / Breathing Problems  Easy Bruising / Bleeding  Liver Disease / Hepatitis  Pins / Metal Implants \_\_\_\_\_
- Blood Pressure Problem  Epilepsy / Seizure Disorder  Leg / Ankle Swelling  Rheumatoid Arthritis
- Blood Disorders  Fainting / Dizziness  Loss Of Consciousness  Smoking
- Bowel / Bladder Problems  Fractures  Lung Problems (Emphysema / COPD / Chronic Bronchitis)  Sprains / Strains
- Broken Bones  Headaches  Mental Illness  Surgeries
- Cancer  Head Injury  Motor Vehicle Accident  Stress
- Cardiac Pacemaker  Heart Problems (Heart Disease / CHF / Arteriosclerosis / Angina/ MI)  Multiple Sclerosis  Stroke / Neurologic History
- Circulation Problems / Clots  Hernia  Other Arthritis (Osteoarthritis, Lupus Erythematosus)  Thyroid Problem
- Chemical, Alcohol or Drug  Immune Suppressed (HIV / AIDS)  Tuberculosis
- Chronic Infections Dependency  \_\_\_\_\_  Urinary Problems / Infections

Are You Pregnant? Yes No Any Surgeries? \_\_\_\_\_

Any previous injury that may affect current care \_\_\_\_\_

Explain and give approximate dates for any items indicated above \_\_\_\_\_

## MEDICAL HISTORY PAGE 2

Are you currently taking medications?  Yes  No Name or Type of Medication \_\_\_\_\_  
Any allergies? \_\_\_\_\_

### Current activity level:

Occupation \_\_\_\_\_

Physical Activities in occupation  Extended Sitting  Standing  Frequent Bending  Heavy Lifting  Computer Work  Driving  Others \_\_\_\_\_

Are you working?  Light Duty  Regular Duty Restrictions \_\_\_\_\_

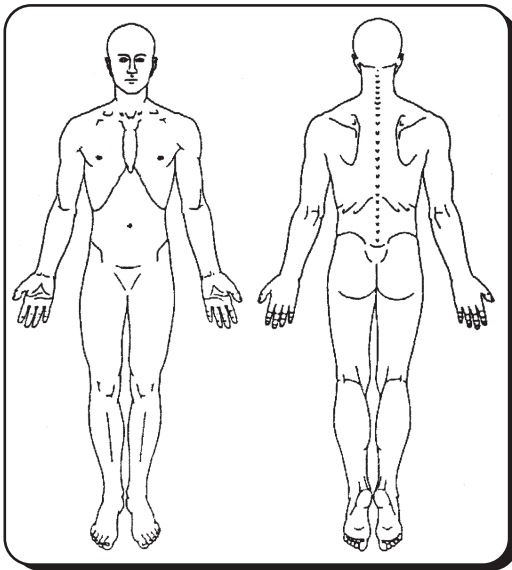
Do you exercise or play sports?  Yes  No List leisure activities (Frequency and hours per week) \_\_\_\_\_

### Are you having difficulties:

- Bathing  Kneeling  Running  Squatting  Other \_\_\_\_\_  
 Bending  Lifting  Sitting  Up/Down Stairs  
 Dressing  Reaching Overhead  Standing  Walking

### PAIN

Please mark on the drawings below the areas where you currently feel pain.



PLEASE MARK THE AREA(S) OF CONCERN

Rate your pain from a scale of 1 to 10, as it is while you are completing this form.

1  2  3  4  5  6  7  8  9  10 (1= minimal 10= severe)

Is your pain getting  Better  Worse  Same

Is your pain  Constant  On and Off  Varies

Type of Pain:  Sharp  Burning  Aching  Tingling  Numbness  Other \_\_\_\_\_

Time of the day the pain is worse:

Upon Waking Up in AM  PM  Varies  
 Mid Day  Late at Night  Same

What makes the pain worse?

Bend  Reach  Stand  
 Cough/Sneeze  Rotate Trunk  Turning Head  
 Deep Breath  Sit  Walk  
 Lie  Sit-Stand  Other \_\_\_\_\_  
 Lift  Stairs

Pain is better with:  Medication  Heat  Ice  Rest  Change in Position  No Relief

Are you able to sleep at night?  Fine  Difficult  Only with Medication

Do you have any other symptoms besides pain? Please describe. \_\_\_\_\_

If you are experiencing any other unusual symptoms or have any other medical conditions not listed, inform your physical therapist or please list here: \_\_\_\_\_

What are your goals/expectations from Physical Therapy? \_\_\_\_\_

Is there anything else you would like to include or ask your physical therapist? \_\_\_\_\_

**Note: No one under the influence of illegal drugs or alcohol may participate in physical therapy at any time.**

I will advise my physical therapist if there are any changes in my condition which could alter my response to any questions on this form.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date