

PATIENT MEDICAL HISTORY

Date: _____ Name: _____ Birth Date: _____

● Problem Location

- Neck Left Shoulder Elbow Wrist Hand
 Back Right Hip Knee Ankle/Foot
 Balance

- On what date did you first experience/notice this problem? _____
- Please tell us where you were, what you were doing (if anything), what happened (if anything) and how bad your injury seemed to be at the time. _____
- _____
- _____
- _____

- Have you had surgery? YES NO (circle one) Date _____
(If you had more than one surgery, enter the date of the last surgery.)
- Describe the surgery. What condition did the surgeon correct? _____
- _____

- On a scale of 0 (none) to 10 (extremely painful) what is your usual pain level? _____
- On the same scale, what is the least level of pain you experience? _____
- When is your pain the least? _____
- On the same scale, what is the worst level of pain you experience? _____
- When is your pain the worst? _____
- Prior to this problem, were you fully functional? YES NO (circle one)
- What is your occupation? _____
- Have you had X-Rays MRI Bone Scan CAT Scan? What were the results? _____
- Is a Home Health Agency assisting you in any way? YES NO (circle one)
- Are you currently seeing or have you seen in the past year, any of the following?
 Physical Therapist YES NO For: _____
 Doctor YES NO For: _____
 Chiropractor YES NO For: _____

- Please check the box if you have recently experienced ...
- Weight Gain/Loss Nausea/Vomiting Fatigue
 Weakness/Dizziness Fever/Chills/Sweats Numbness/Tingling
- Indicate which of the following over-the-counter medications you have taken in the last week.
- Aspirin Laxatives Advil/Tylenol/Ibuprofen
 Antihistamines Antacid Decongestants
 Vitamins/Mineral Supplements Other _____
- Please list all the prescription medications you are currently taking _____
- _____

- Do you smoke? YES NO (circle one) If 'YES', how much do you smoke? _____

- Do you have any bowel or bladder problems? YES NO (*circle one*)
- Any frequent coughing or sneezing? YES NO (*circle one*)
- Do you have frequent headaches? YES NO (*circle one*)
- Do you use Wheelchair Cane Walker Crutches Bracing Other
- Please indicate if you have ever been diagnosed with any of the following
 - Cancer Heart Condition Circulation Problems
 - Stroke Respiratory Problems High Blood Pressure
 - Hepatitis Infectious Disease Tuberculosis
 - Anemia Thyroid Problems Kidney Disease
 - Diabetes Epilepsy Rheumatoid Arthritis
 - Osteoporosis Vertigo Other Arthritic Conditions
- Do you have a pacemaker? YES NO (*circle one*)
- Do you have any implants? YES NO (*circle one*)
- Does your home have stairs that you must climb on a regular basis? YES NO
- Is there someone in your home to assist you during your rehab? YES NO
- Please tell us any other information that you think might be helpful in developing and implementing your treatment plan. Make sure to tell us of any precautions we must consider during your care. If you have any other conditions that could impact your treatment it is critical that you let your therapist know. _____

Patient Signature: _____	Date _____
Parent/Guardian: _____ <i>(if patient is under 18)</i>	Date _____

Therapist Notes: _____ _____ _____ _____ _____ _____ _____ _____ _____
I have reviewed this document with the patient.

Therapist: _____	Signature: _____
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