Howard County
Physical Therapy Sports Rehabilitation

Medical History

Under Medicare and the State practice acts, we are required to obtain a complete medical history on all patients. This information is protected under HIPAA laws. Please answer all questions to the best of your ability.

Last Name: _____ **First Name**: _____ **MI:** ____Date: _____

DOB: _____ Age: _____ Sex: M / F Hand Dominance: R / L Height:_____ Weight: _____

How did you hear about us? _____

Primary Care Doctor: _____Referring Doctor: _____

If accident, circle place where occurred: Home Auto Work Sports Other Next Doctor's Visit: _____

Occupation: _____ Work involved? _____ Current Work Status: _____

Do you have any lifting restrictions? Y / N Do you live alone? Y / N Are there stairs where you live? Y / N

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Briefly describe how your problem began: _____

What goals would you like to achieve through therapy? _____

Date of onset/injury: _____ Date of surgery: _____ Type of surgery: _____

Previous treatments: (Circle all that apply) ☐ No prior treatment

Physical Therapy Chiropractic Care Home Care Rehab Facility Pain Management

What body area was treated? _____ When? _____

Have any diagnostic tests been performed for this problem? (Circle all that apply)

X-rays MRI CT Scan Other:_____

Please list body part tested and date tested: _____

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Where is your pain ? _____

Since it started, pain is: ☐ getting worse ☐ improving ☐ the same

Describe pain: ☐ sharp ☐ dull ☐ aching ☐ sore ☐ throbbing

☐ cramping ☐ burning ☐ shooting ☐ stabbing

☐ squeezing ☐ constant ☐ intermittent

☐ Other:_____

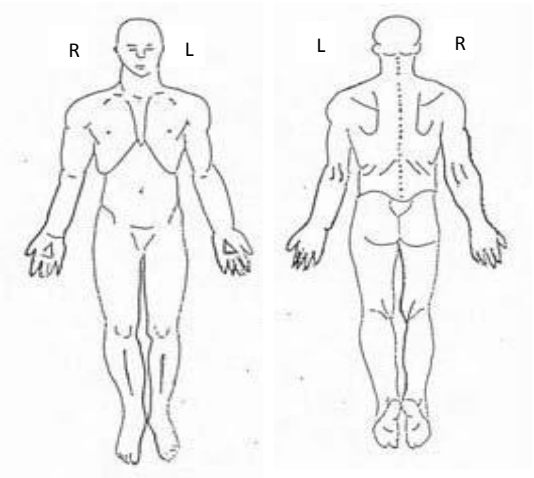
What makes it worse?_____

What makes it better? _____

Sleeping tolerance limited Y / N Sitting tolerance limited Y / N

Standing tolerance limited Y / N Walking tolerance limited Y / N

Place an X on areas of pain



Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Least Pain:	0	1	2	3	4	5	6	7	8	9	10
Worst Pain:	0	1	2	3	4	5	6	7	8	9	10
Today:	0	1	2	3	4	5	6	7	8	9	10

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Have you fallen *two (2) or more times* within the past 12 months? Y / N

Have you sustained an injury as a result of these falls? Y / N

Do you use any of the following: ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair

How would you rate your current health? ☐ excellent ☐ very good ☐ good ☐ fair ☐ poor

Please circle yes or no if you have or have had any of the following conditions:

High Blood Pressure	Y / N	Diabetes	Y / N	Osteoarthritis	Y / N
High Cholesterol	Y / N	Heart Attack	Y / N	Rheumatoid Arthritis	Y / N
Bowel/Bladder Dysfunction	Y / N	Cardiac Bypass	Y / N	Osteoporosis or Osteopenia	Y / N
Acid Reflux or Ulcers	Y / N	Cardiac Stents	Y / N	Scoliosis	Y / N
Thyroid disorder	Y / N	Angina/Chest Pain	Y / N	Headaches or Migraines	Y / N
Bleeding disorder	Y / N	Hepatitis	Y / N	Dizziness or Fainting	Y / N
Seizures/Epilepsy	Y / N	Emphysema	Y / N	Cancer (site:)	Y / N
Lyme Disease	Y / N	COPD	Y / N	Recent Infection	Y / N
Currently pregnant-#wks _____	Y / N	Asthma	Y / N	Multiple Sclerosis	Y / N
Fibromyalgia	Y / N	Kidney Disease	Y / N	Congestive Heart Failure	Y / N
Lupus	Y / N	Stroke	Y / N	Depression	Y / N
Are you a tobacco user?	Y / N				

Other not listed: _____

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Do you have any tingling, numbness or loss of sensation? Y / N If so, where? _____

Do you have any weakness? Y / N If so, for how long? _____

Do you have any swelling? Y / N If so, where? _____

Other Concerns? _____

Surgical History

Orthopedic:

☐ Hip Replacement	☐ Right	☐ Left	☐ Both
☐ Knee Replacement	☐ Right	☐ Left	☐ Both
☐ Shoulder Replacement	☐ Right	☐ Left	☐ Both
☐ Hip	☐ Right	☐ Left	☐ Both
☐ Knee	☐ Right	☐ Left	☐ Both
☐ Ankle / Foot (circle)	☐ Right	☐ Left	☐ Both
☐ Shoulder	☐ Right	☐ Left	☐ Both
☐ Elbow	☐ Right	☐ Left	☐ Both
☐ Wrist / Hand (circle)	☐ Right	☐ Left	☐ Both

Spine Surgery:

☐ Cervical (neck)
☐ Lumbar (lower back)

Cortisone / Epidural Injections:

Joint/Date_____

Other Surgeries:

_____

To the best of my ability, I have given and included all pertinent medical information.

Patient/Guardian signature: _____ Date: _____

Medical history reviewed by physical therapist and used in determining the plan of care.

Therapist signature: _____ Date: _____

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