

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

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: _____

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: _____

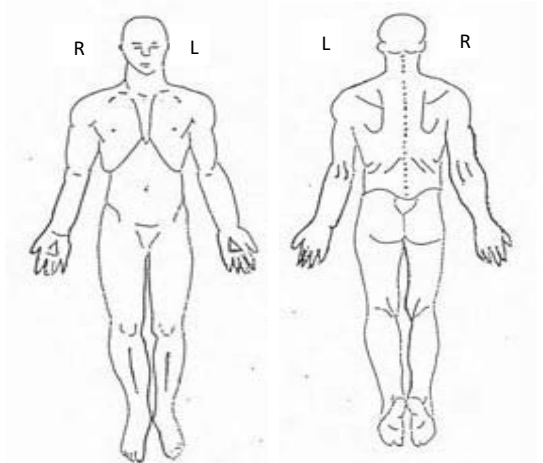
What makes it worse? _____

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

Medical History

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				

* Date of Diabetes Diagnosis: _____

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: \_\_\_\_\_