

### 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: \_\_\_\_\_

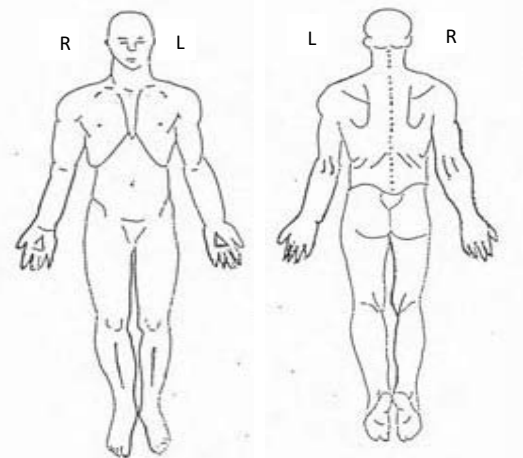
What makes it worse? \_\_\_\_\_

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: \_\_\_\_\_