



Medical History

Name: _____ Today's Date: _____

Referring Physician: _____ Primary Doctor _____

What are we seeing you for today? _____

Date of injury/onset of symptoms: (mm/dd/yy) _____

How did it occur? _____

List any previous treatments for this episode: _____

1. Have you had any of the following tests for this specific incident?

___ CT scan ___ MRI ___ X-ray ___ EMG ___ Bone scan

2. List any surgeries received: _____

3. Any recent health changes (i.e., significant weight gain/loss; bowel/bladder problems; fever; dizziness; changes in vision and/or speech, etc.)? _____

4. Are you taking any medications? (please list) _____

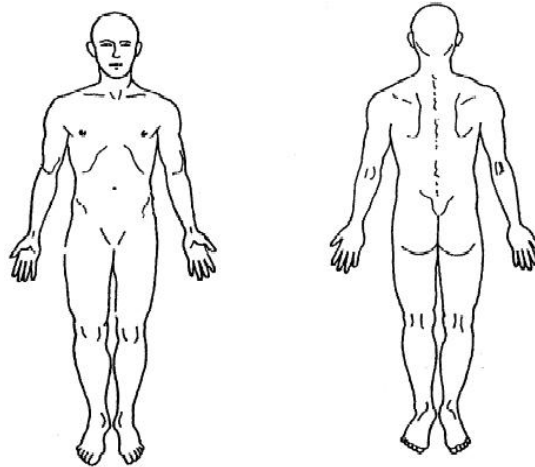
5. Allergies to tape/medications? (please list) _____

6. Please check () if you have had problems with or been treated for:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Head Trauma/Concussion | <input type="checkbox"/> High blood pressure (Hypertension) |
| <input type="checkbox"/> Difficulty Swallowing | <input type="checkbox"/> Irregular Heart Beats | <input type="checkbox"/> Frequent Falls |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Jaw Problems | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Muscular Weakness | <input type="checkbox"/> Epilepsy, Seizures, Convulsions |
| <input type="checkbox"/> Wound that does not Heal | <input type="checkbox"/> Stomach Pains or Ulcers | <input type="checkbox"/> Chest Pain/Pressure at Rest |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Night Pain (while sleeping) |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cancer | <input type="checkbox"/> Constant Pain Unrelieved by Rest |
| <input type="checkbox"/> Unusual Skin Coloration | <input type="checkbox"/> Pain with Cough or Sneeze | <input type="checkbox"/> Nervous or Emotional Problems |
| <input type="checkbox"/> Weakness or Fatigue | <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Unexplained Weight Loss |
| <input type="checkbox"/> Calf Pain with Exercise | <input type="checkbox"/> Joint Dislocation(s) | <input type="checkbox"/> Constant Pain or Pressure |
| <input type="checkbox"/> Lung Disease/Problems | <input type="checkbox"/> Back or Neck Injuries | <input type="checkbox"/> Pacemaker/Implanted Stimulator |
| <input type="checkbox"/> Hernias | <input type="checkbox"/> Diabetes Type I__ Type 2__ | <input type="checkbox"/> Any infectious Disease (TB, AIDS, Hepatitis) |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Broken Bone | |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke(s) | |
| <input type="checkbox"/> Blurred Vision | <input type="checkbox"/> Balance Problems | |
| <input type="checkbox"/> Recent Accident | <input type="checkbox"/> Difficulty Sleeping | |
| <input type="checkbox"/> Swollen and Painful Joints | <input type="checkbox"/> Muscular Pain with Activity | |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Swollen Ankles or Legs | |

Other: _____

7. Describe your pain and mark areas of pain with an "X" and areas of numbness/tingling with "O".



My pain is: ___aching___burning___stabbing___pins and needles___dull___sharp___

Rank your pain on a scale of 0 - 10.

0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Intensely severe Emergency Room

8. Is your pain worse in the Morning / Afternoon / Evening? (circle one)

9. Is your pain constant / periodic? (circle one)

10. What makes your pain worse? _____

11. What eases your pain? _____

12. Check if you are having pain or difficulty with any of the following:

Walking: ___ If so, how far can you walk? _____

Standing: ___ If so, how long can you stand? _____

Sitting: ___ If so, how long can you sit? _____

Bending Forward: _____

Dressing Self: _____

Reaching into Cupboard: _____

Stair Climbing: _____

Repetitive Movements: ___ Please describe: _____

Sleeping: ___ If so, describe your pillow and position you sleep. _____

Specific Sports: ___ Please explain: _____

13. What are your goals for Physical Therapy?

14. When is your next doctor's appointment? _____



HANDS ON
PHYSICAL THERAPY, PC