



## Patient Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Referring MD: \_\_\_\_\_ Primary MD: \_\_\_\_\_

Please list any medications you are currently taking (including pills, injections, and/or skin patches)

\_\_\_\_\_

Have you had Physical Therapy or other treatment for this problem? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Has your physician ordered any tests for this diagnosis? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please circle: X-Ray CT Scan MRI EMG Nerve Conduction Velocity Other: \_\_\_\_\_

Results: \_\_\_\_\_

Please check if you have had any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Aids/ HIV              | <input type="checkbox"/> Alcohol/Chemical Dependency | <input type="checkbox"/> Arthritis                |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Blood Clots              |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Bladder Problems            | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Bowel Problems         | <input type="checkbox"/> Bronchitis                  | <input type="checkbox"/> Congestive Heart Disease |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> Coronary Heart Disease   |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> Emphysema                |
| <input type="checkbox"/> Epilepsy               | <input type="checkbox"/> Fainting                    | <input type="checkbox"/> Gout                     |
| <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Heart Surgery               | <input type="checkbox"/> Headaches                |
| <input type="checkbox"/> Hernia                 | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> Infectious Disease       |
| <input type="checkbox"/> Osteoporosis           | <input type="checkbox"/> Pacemaker                   | <input type="checkbox"/> Pins/Metal Implants      |
| <input type="checkbox"/> Psychological Problems | <input type="checkbox"/> Radiation                   | <input type="checkbox"/> Shortness of Breath      |
| <input type="checkbox"/> Sleeping Problems      | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Thyroid Disease          |
| <input type="checkbox"/> Varicose Veins         | <input type="checkbox"/> Weakness                    | <input type="checkbox"/> Weight/Energy loss       |

Surgeries / Hospitalization: \_\_\_\_\_

Are you Pregnant: \_\_\_\_\_ Yes \_\_\_\_\_ No

What are your goals for Physical Therapy? \_\_\_\_\_

\_\_\_\_\_

Is there any other information we should know regarding your care?

\_\_\_\_\_

Using the 0 to 10 scale, with 0 being "no pain" and "10" being "the worst pain imaginable", please describe:

Current level of pain \_\_\_\_\_ Best level of pain in the last 24 hrs \_\_\_\_\_ Worst level of pain in the last 24 hrs \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_