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:

☐ Aids/ HIV	☐ Alcohol/Chemical Dependency	☐ Arthritis
☐ Anemia	☐ Allergies	☐ Blood Clots
☐ Asthma	☐ Bladder Problems	☐ Cancer
☐ Bowel Problems	☐ Bronchitis	☐ Congestive Heart Disease
☐ Chemotherapy	☐ Chest Pains	☐ Coronary Heart Disease
☐ Dizziness	☐ Diabetes	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ Gout
☐ Heart Attack	☐ Heart Surgery	☐ Headaches
☐ Hernia	☐ High Blood Pressure	☐ Infectious Disease
☐ Osteoporosis	☐ Pacemaker	☐ Pins/Metal Implants
☐ Psychological Problems	☐ Radiation	☐ Shortness of Breath
☐ Sleeping Problems	☐ Stroke	☐ Thyroid Disease
☐ Varicose Veins	☐ Weakness	☐ 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: _____