MEDICAL HISTORY

Name: ____________________________________ Age: _________ DOB: ___________________

Describe your current complaint:____

____

When did your condition begin? ___________________ How did your problem begin? __________________

____

Have you been treated for this same problem in the past? Yes or No

If yes, please describe: ____

Have you had Surgery? Yes or No

If yes, please describe: ____

Current level of pain (0 = no pain, 10 = require emergency room care):

At rest: 1 2 3 4 5 6 7 8 9 10

At movement: 1 2 3 4 5 6 7 8 9 10

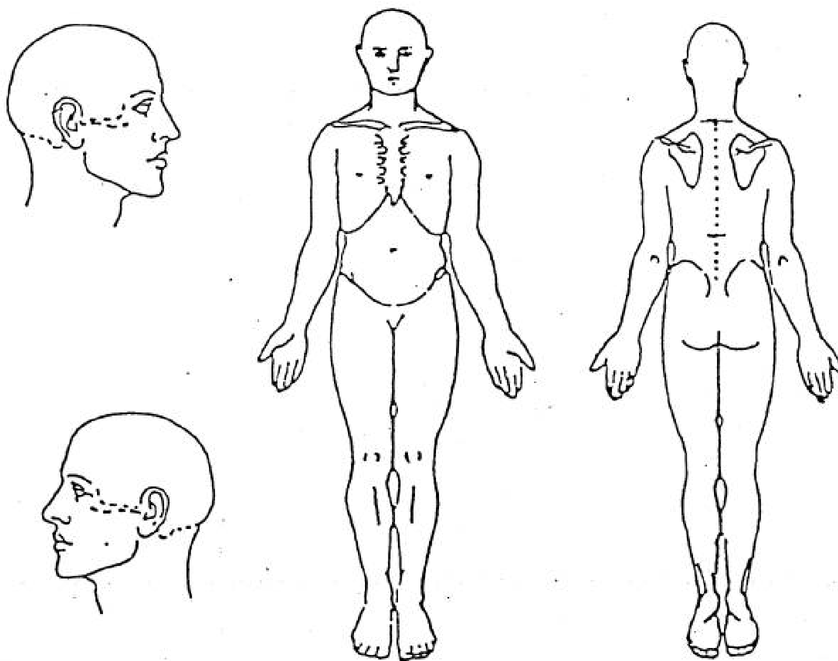
Since your condition began, have your symptoms: decreased not changed increased

What makes your problem better? ____

What makes your problem worse? ____

What percentage of the time are your symptoms present? 0% 25% 50% 75% 100%

Please mark on the drawings below where you feel your pain:



PT INITALS: ___________

Please Check any of the following services that you have received for this condition:

____ Orthopedist	____ Physical Therapy	____ X-Rays	____ EMG
____ Chiropractor	____ Occupational Therapy	____ CT Scan	____ NCV
____ Neurologist	____ Massage Therapy	____ MRI	____ Injection
____ General Practitioner		____ Myelogram	____ Cast or Brace
____ Emergency Room		____ other:	

Have you had other treatment for this **current** condition? Yes or No

If yes, please describe: ____

Please list any medications you are currently taking: ____

____

____

Please check any of the following that are in your health history:

___ Asthma	___ Sleeping Problems	___ Allergies
___ Shortness of Breath	___ Emotional/Psychological	___ Anemia
___ Coronary Artery Disease	___ Headaches	___ Infectious Disease
___ Chest Pain	___ Numbness/Tingling	___ Neurological Problems
___ Pacemaker	___ Dizziness or fainting	___ Diabetes
___ High Blood Pressure	___ Blurred Vision	___ Metal Implants
___ Heart Attack	___ Ringing in the Ears	___ Cancer
___ Heart Surgery	___ Weakness	___ Smoking
___ Stroke or TIA	___ Weight Loss	___ Arthritis/swollen joints
___ Blood clot or emboli	___ Night sweats	___ Are you Pregnant?
___ Epilepsy or Seizures	___ Hernia	___ Osteoporosis
___ Thyroid trouble or Goiter	___ Varicose Veins	___ Incontinence

___ Fearful of water (in regard to Aquatic Therapy)

Please list any past surgeries: ____

____

____

Please list any past hospitalizations: ____

____

____

Please list three goals you would like to achieve while in physical therapy:

1. ____
2. ____
3. ____

Patient/Guardian Signature: ______________________________ Date: ______________

I have read and reviewed the medical history of ______________________________.

______________________________ ______________

Physical Therapist Signature Date

OFFICE USE ONLY:

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