Medical History Form

Please take a few minutes to answer the following questions about your health and lifestyle to assist us in expediting your evaluation.

* Required

1. Patient Name

2. Date of birth

Example: January 7, 2019

3. Height

4. Weight

5. What is your reason for needing therapy today?

6. When and how did your problem begin?

Past Medical Information

7. Do you have or have you ever had any of the following? (check all that apply)

Check all that apply.

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Infection
- [ ] Diabetes
- [ ] Heart attack
- [ ] Heart problems
- [ ] Lung/respiratory problems
- [ ] Asthma, Bronchitis, or Emphysema
- [ ] Bladder dysfunction
- [ ] Osteoporosis
- [ ] Cancer
- [ ] Rheumatoid arthritis
- [ ] Osteoarthritis
- [ ] Dizziness or fainting
- [ ] Neck injury or surgery
- [ ] Back injury or surgery
- [ ] Knee injury or surgery
- [ ] Leg/Ankle/Foot injury or surgery
- [ ] Shoulder/Elbow/Hand injury or surgery
- [ ] Blood clot/emboli
- [ ] Stroke/TIA
- [ ] Epilepsy/Seizures
- [ ] Any pins or metal implants?
- [ ] Joint replacement
- [ ] Vision or hearing difficulties
- [ ] Allergies
- [ ] Pacemaker/Implant
- [ ] Neurological disease
- [ ] Pregnant

Other: [ ] ____________________

8. If you checked any of the boxes above, please explain in more detail below.

Such as date of surgery, specific location of injury, etc.

9. Is there anything that your doctor told you not to do?

Leave blank if not applicable

10. Have you had physical therapy previously for the same problem?

Leave blank if not applicable

11. Are you receiving other treatments for this problem at this time?

Leave blank if not applicable

12. What kind of tests have been done for your current problem?

Leave blank if not applicable

Mark only one oval.

- MRI
- X-Ray
- CT Scan
- Other: ____________________

13. Have you been hospitalized in the past year for this condition? If yes, when and for how long?

Leave blank if not applicable

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14. Does anyone come to your home to provide health care needs (nursing, social work, physical/occupational/respiratory needs)?

Leave blank if not applicable

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15. When is your next appointment with the doctor who sent you to us?

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Example: January 7, 2019

Pain Information

16. Do you have pain now?

Mark only one oval.

- ⬭ Yes
- ⬭ Maybe
- ⬭ No

17. When you do have pain, what doe the pain feel like? (check all that apply)

Check all that apply.

- [ ] Sharp/Knifelike
- [ ] Shooting/Radiating
- [ ] Stabbing
- [ ] Aching
- [ ] Dull
- [ ] Constant
- [ ] Pins and needles
- [ ] Numbness/Tingling
- [ ] Burning
- [ ] Intermittent
- [ ] Tight
- [ ] Pulling

Other: [ ] ______________________________

18. What time of day do you feel the least pain?

Mark only one oval.

- Morning
- Afternoon
- Evening
- Night
- Other: ____________________

19. What time of day do you feel the most pain?

Mark only one oval.

- Morning
- Afternoon
- Evening
- Night
- Other: ____________________

20. What positions or activities make the pain increase or decrease?

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21. Does the pain interfere with your daily life? If yes, explain how.

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22. Rate your pain

Mark only one oval.

	1	2	3	4	5	6	7	8	9	10	
No pain	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	⬭	Unbearable pain

Balance Information

23. Have you fallen in the last 6 months? How many times?

Leave blank if not applicable

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24. Have you had a decrease in your activity level because of a fear of falling?

Mark only one oval.

- ⬭ Yes
- ⬭ Maybe
- ⬭ No

25. Are you reluctant to leave your home because of a fear of falling?

Mark only one oval.

- ( ) Yes
- ( ) Maybe
- ( ) No

Medication Information

26. Please list all your current medications and their dosages. Please include herbal preparations/vitamins. Alternatively, have a copy available for your therapist at the first session.

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Physical Therapy Goals

27. What are your goals as a result of attending physical therapy? (check all that apply)

Check all that apply.

- [ ] Decrease pain
- [ ] Improve strength
- [ ] Less difficulty with work activities
- [ ] Walk longer distances
- [ ] Stand longer periods of time
- [ ] Sleep longer periods of time
- [ ] Sit longer periods of time
- [ ] Improve movement
- [ ] Less difficulty with home activities
- [ ] Return to recreational activities / sports activities

Other: [ ] ____________________

Signature

By my signature below, I certify that the information I have provided above is complete, accurate, and truthful to the best of my knowledge.

28. Electronic Signature of Patient or Guardian *

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