Medical History Form

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Patient Name: (please print): _____	Today's Date: _____		
**Date your symptoms started:____/____/_____	Weight (lbs): ____	Age:_____	Height: ___ ft ___ in

1. YOUR HEALTH HISTORY:			
YES	**NO**	Do you have a **pacemaker**?	
YES	**NO**	Do you have a **latex allergy**?	
YES	**NO**	**WOMEN:** Are you or could you be pregnant?	
YES	**NO**	Have you been recently hospitalized or gone to the emergency room? (provide dates & reason)	
YES	**NO**	Do you smoke/use tobacco?	
		Off work due to injury since: **___/___/20__**	
YES	**NO**	Are you allergic to any medications? (please list)	
YES	**NO**	Have you ever taken **steroid medications** for any medical conditions?	
YES	**NO**	Have you ever taken **blood thinner** or **anticoagulant medications** for any medical conditions?	
		How many times have you fallen this past year **without injury**?	
		How many times have you fallen this past year and **been injured?**	
YES	**NO**	During the past month have you been feeling down, depressed or hopeless?	
YES	**NO**	During the past month have you been bothered by having little interest or pleasure in doing things?	
YES	**YES, BUT NOT TODAY**	**NO**	Is this something with which you would like help?
YES	**NO**	Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way?	

2. YOUR MEDICAL HISTORY:			**(please CIRCLE all that apply now or in the past)**								
Y	**N**	Cancer	**Y**	**N**	Osteoporosis	**Y**	**N**	Asthma	**Y**	**N**	Pneumonia
Y	**N**	Heart Attack	**Y**	**N**	Lung Problems	**Y**	**N**	Diabetes	**Y**	**N**	Liver problems
Y	**N**	Chest Pain	**Y**	**N**	Tuberculosis	**Y**	**N**	HIV/AIDS	**Y**	**N**	Cough/Wheeze
Y	**N**	Ulcers/ vascular disease	**Y**	**N**	Vision problems	**Y**	**N**	Leg or Arm swelling	**Y**	**N**	Aneurysm (you/ your family)
Y	**N**	Stroke	**Y**	**N**	Rheumatoid Arthritis	**Y**	**N**	Osteoarthritis	**Y**	**N**	High cholesterol
Y	**N**	Epilepsy	**Y**	**N**	Osteopenia	**Y**	**N**	Sleep apnea	**Y**	**N**	Blood Clots
Y	**N**	Hepatitis	**Y**	**N**	Neurologic disorder	**Y**	**N**	Ephysema	**Y**	**N**	GERD/ Reflux
Y	**N**	Depression	**Y**	**N**	Anxiety	**Y**	**N**	Gout	**Y**	**N**	Thyroid Disease

Please list ALL prescription & over the counter medications, vitamins and herbal supplements you are currently taking. (Please ask if you need an expanded form for your medication list).

Medication Name	Dosage	Frequency	Route: Oral, Injection, Inhalant, Topical etc.

Please list all past surgical procedures and dates:

3. HOW YOU FEEL NOW

What pain or concern are you coming for today?

Is this condition: ❑Work related ❑Sports injury ❑Car Accident ❑Other:
Off work due to injury since: **___/___/20__**

Describe what happened/What do you think caused your symptoms?

YES	**NO**	Have you had these symptoms before - **when?**
YES	**NO**	Have you had other treatments for this condition (chiro, meds, injections, acupuncture, PT) **What helped/flared/resulted in no change?**

Please list special tests performed for this problem (x-ray, MRI, labs, etc):

My symptoms are **WORSE** when:	Sitting	Standing	Lying Down	Walking
My symptoms are **BETTER** when:	Sitting	Standing	Lying Down	Walking
My symptoms are:	Getting Better	Worse		Staying the Same
My best time of day is:	Morning	Afternoon	Evening	Overnight

What kind of work/hobbies do you do?	
What movements/positions does your job require you to perform?	

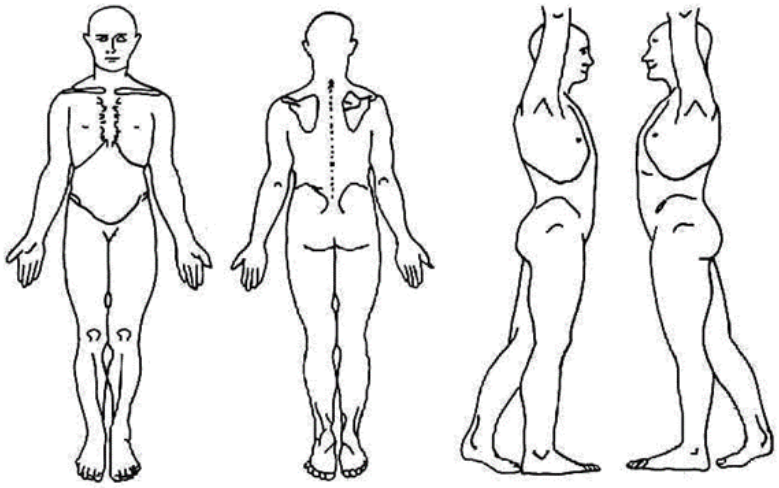
4. IN THE PAST YEAR HAVE YOU EXPERIENCED ANY OF THE FOLLOWING?

YES	**NO**	Fatigue	**YES**	**NO**	Dizziness/lightheadedness	**YES**	**NO**	Difficulty breathing
YES	**NO**	Weakness	**YES**	**NO**	Fever/Chills/Sweats	**YES**	**NO**	Poor balance/Falls
YES	**NO**	Weight Loss/Gain	**YES**	**NO**	Incontinence of urine or feces	**YES**	**NO**	Change in memory/thinking
YES	**NO**	Nausea/Vomiting	**YES**	**NO**	Heartburn/indigestion	**YES**	**NO**	Numbness/tingling
YES	**NO**	Night pain	**YES**	**NO**	Bladder changes	**YES**	**NO**	Chest pain
YES	**NO**	Bowel changes	**YES**	**NO**	Shortness of breath	**YES**	**NO**	Vision changes

5. YOUR SYMPTOM SCALE	**0** = ***No Pain or Distress***									***Unbearable Pain or Distress*** = **10**
Right at this moment	0	1	2	3	4	5	6	7	8	9	10
At its **BEST** in the last 2 days	0	1	2	3	4	5	6	7	8	9	10
At its **WORST** in the last 2 days	0	1	2	3	4	5	6	7	8	9	10

Mark the areas of your symptoms on the body chart to the right :

P = pain
T = tingling
N = numbness
B = burning
C = cramping
S = shooting



Aggravating Factors: Identify up to 3 important Positions or activities that make your symptoms worse:

1._____

2. _____

3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1._____

2. _____

3. _____

6. ACKNOWLEDGEMENT: I understand that all medical data in this form is required for my physical therapist to design the appropriate treatment plan for me. By signing this document I certify that this information is accurate, complete and to the best of my knowledge.

Date: _____

Client/Parent/Guardian/Authorized Representative _____

If not signed by client, relationship to the client_____