PATIENT MEDICAL HISTORY – PHYSICAL THERAPY

Date:_____ Date of birth/Age:_____
Name:_____
Contact number during the day:_____
Referring Physician:_____Primary Care Provider:_____
Date of injury:_____Last day of work due to injury:_____
Occupation:_____Are you right or left handed? (circle one)
Please list any prescriptions or over-the-counter medications you are taking: _____
_____

Are you allergic to any medications? Yes/No Please list:_____
Do you have a latex allergy? Yes/No _____
Please list any physicians you have seen or treatments you have had for this injury:_____
_____

Have you had any diagnostic imaging for this injury? Yes/No If yes, please list type, date performed, and facility where performed:_____

Have you had surgery for this injury? Yes/No If yes, please describe, give date and surgeon:_____
_____

Have you had any other surgeries? Yes/No If yes, please describe:_____
_____

Do you now have or have you ever had any of the following:

Asthma/Bronchitis	Yes/No	Headaches: tension/migraine	Yes/No
Emphysema	Yes/No	Vision/hearing problems	Yes/No
Shortness of breath	Yes/No	Dizziness/fainting	Yes/No
Chest pain	Yes/No	Bowel/bladder problems	Yes/No
Congestive heart disease	Yes/No	Weakness	Yes/No
High blood pressure	Yes/No	Weight/energy loss	Yes/No
Heart attack	Yes/No	Hernia	Yes/No
Stroke/TIA	Yes/No	Varicose veins	Yes/No
Blood clot/emboli	Yes/No	Allergies, list:_____	Yes/No
Epilepsy/seizures	Yes/No	Pins/metal implants:_____	Yes/No
Thyroid/goiter	Yes/No	Anemia	Yes/No
Infectious diseases	Yes/No	Cancer, type:_____	Yes/No
Diabetes, Type 1 or 2	Yes/No	Chemotherapy/radiation	Yes/No
Arthritis, type_____	Yes/No	Osteoporosis	Yes/No
Gout	Yes/No	Emotional/psychological problems	Yes/No
Sleeping problems	Yes/No	Current pregnancy	Yes/No
Current tobacco use	Yes/No	AIDS/HIV	Yes/No
Multiple Sclerosis	Yes/No	Sexually transmitted disease	Yes/No

Explain any yes answers and give dates:_____
_____
_____

Please complete the other side of this paper

PATIENT MEDICAL HISTORY – PAGE TWO

Please describe how your problem or injury began: _____
_____

Since your problem began, has it been getting worse, staying the same, or getting better? (circle one)

What activities or positions aggravate your pain or dysfunction? _____
_____

What makes your pain or dysfunction better? _____
_____

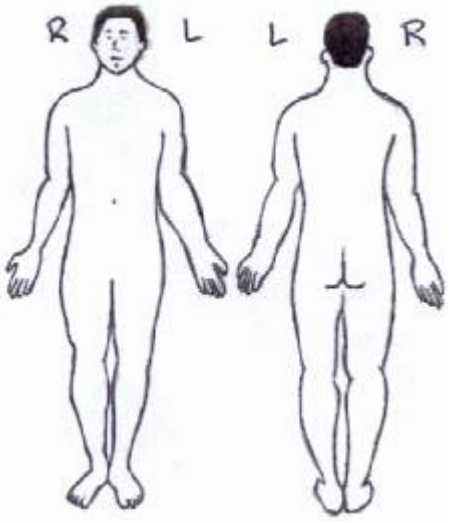
Are there activities that you cannot do because of pain or dysfunction? Please list: _____
_____

Are there activities that you are able to do but are difficult because of your pain or dysfunction? Please list:_____
When are your symptoms worst? (circle one) when you first get up, AM, PM, varies with activity level
Is your sleep disturbed by pain? Yes/No
How many times per night do you wake up due to pain?_____

Please mark your level of pain on the line below: Put an X on best and worst pain level and an * on current pain level.

|_____|_____|
no pain moderate pain severe pain

Please mark on the diagram where your symptoms are and describe the symptoms:



Are you aware of your diagnosis and prognosis as explained to you by your primary care provider? Yes/No

Based on your awareness, what are your rehabilitation expectations/goals from this program?