



## PATIENT MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Left or Right Handed

Family Physician \_\_\_\_\_

How did you hear about us? M.D. \_\_\_\_\_ Friend/Name \_\_\_\_\_ Other \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

If accident, place where occurred: Home Work Auto Other \_\_\_\_\_

Briefly describe what happened and/or what is bothering you: \_\_\_\_\_

\_\_\_\_\_

On a scale from 0 (no pain) to 10 (severe pain) please rate your pain level: \_\_\_\_\_

What makes it better? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Have you been treated previously for this condition? Yes No

Where? \_\_\_\_\_ When? \_\_\_\_\_

Where? \_\_\_\_\_ When? \_\_\_\_\_

List all medication you are taking including "over the counter" and herbals: \_\_\_\_\_

\_\_\_\_\_

List all operations in the past: \_\_\_\_\_

\_\_\_\_\_

Check appropriate history of past/present conditions:

Heart	YES	NO	Tuberculosis	YES	NO
High Blood Pressure	YES	NO	Hepatitis/Liver	YES	NO
Circulation	YES	NO	Kidney or Bladder	YES	NO
Phlebitis/Blood Clots	YES	NO	Mental or Emotional	YES	NO
Asthma/Emphysema/Lung	YES	NO	Lyme Disease	YES	NO
Diabetes	YES	NO	Arthritis	YES	NO
Thyroid	YES	NO	Cancer	YES	NO
Epilepsy/Seizure/Convulsions	YES	NO	Ulcer or Gastro-Intestinal	YES	NO
Stroke	YES	NO	Allergies	YES	NO
Neck/Back	YES	NO	Other _____		
Pregnancy (current)	YES	NO			

What goals would you like to achieve through physical therapy? \_\_\_\_\_

\_\_\_\_\_

If applicable: Do you want a Social Services consult? \_\_\_\_\_