Medical History Form

Name:_____ **Date:**_____

Height:_____ **Weight:**_____ **DOB:**_____

Describe your current symptoms / chief complaints: _____

_____

_____ **[Approx.] Start Date:** _____

Related testing? X-Rays MRI EKG EMG CT Scan Bone Scan Arthrogram *(circle all that apply)*

Other: _____

Did you have surgery for this condition? Yes No

Are you seeing, or have you seen, any other healthcare providers for this condition? Yes No

Describe other treatment for this condition: _____

_____

Have you had similar symptoms in the past? Yes No

If yes, please describe past treatment: _____

_____

What makes your pain worse? _____

What eases your pain? _____

As of today, have your symptoms gotten: Better Worse Unchanging

As the day progresses, do your symptoms: Increase Decrease Stay the same

What are your physical therapy goals? _____

_____

Are you currently employed? Yes No Retired Restricted Duty

If no, is it because of this injury/illness? Yes No

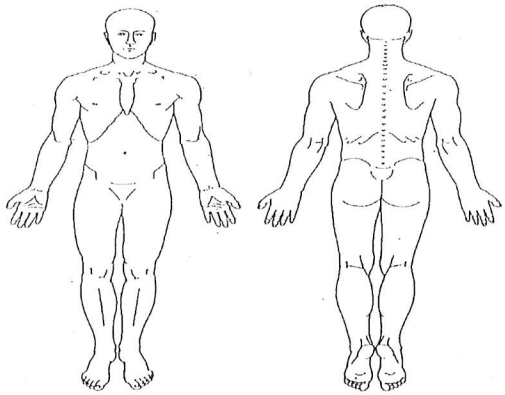
Is this injury the result of an auto accident? Yes No

What is your occupation? _____

What are your job duties? _____

Current medications: _____

Pain location:
(shade where appropriate)



Pain description: *(select all that apply)*

- ❑ Sharp
- ❑ Dull
- ❑ Burning
- ❑ Throbbing
- ❑ Electrical
- ❑ Cramping
- ❑ Numbness/Tingling
- ❑ Other: _____
- ❑ No pain

Please rate your ability to perform the following:
1- Not limited 2-Some difficulty 3-Significant difficulty 4-Unable

Dressing _____
Driving _____
Sitting _____
Stairs _____
Standing _____
Sporting activities _____
Walking _____
Housework _____
Yardwork _____
Sleeping _____
Lifting/Carrying _____
Pushing/Pulling _____

Pain rating:

0=None 5=Moderate 10=Extreme

At worst: 0 1 2 3 4 5 6 7 8 9 10

Current: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

How often do you have symptoms?

Constantly (76-100% of the day)
Frequesntly (51-75% of the day)
Occasionally (26-50% of the day)
Intermittently (0-25% of the day)

Do you have, or have you had any of the following: *(select all that apply)*

- ❑ Arthritis
- ❑ Asthma
- ❑ Broken bones
- ❑ Cancer
- ❑ Dementia
- ❑ Depression
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Fibromyalgia
- ❑ Head injury
- ❑ Heart problems
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ Joint dislocation
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Parkinson's Disease
- ❑ Rheumatoid arthritis
- ❑ Skin Condition
- ❑ Stroke
- ❑ Thyroid problems

Any other previous injuries or illnesses that may affect current care: _____

Within the past year, have you had any of the following symptoms? *(select all that apply)*

- ❑ Chest pain
- ❑ Headaches
- ❑ Loss of balance
- ❑ Joint pain/swelling
- ❑ Difficulty sleeping
- ❑ Fever/chills/sweats
- ❑ Heart palpitation
- ❑ Nausea/vomiting
- ❑ Hearing problems
- ❑ Difficulty walking
- ❑ Loss of appetite
- ❑ Vision problems
- ❑ Pain at night
- ❑ Urinary problems
- ❑ Bowel problems
- ❑ Weight loss/gain
- ❑ Shortness of breath
- ❑ Coordination problems
- ❑ Dizziness/blackouts
- ❑ Difficulty swallowing

Are you now, or have you ever been, a smoker? Yes No

Are you currently, or are you planning to be, pregnant? Yes No

What is your dominant hand? Left Right Ambidextrious