PATIENT MEDICAL HISTORY FORM

Name: ____ Age: _________________

Occupation: _______________________________ Job Duties: _______________________________________

Is your problem associated with some accident or injury? Yes: _________ No: ___________

If yes, briefly Explain: ____

Date of injury/ onset of symptoms: _____________________________If applicable, date of surgery: __________

How would you describe your symptoms? ____

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=severe pain)

No pain | Mild pain w/ movement | Medium pain w/ movement | High pain w/ movement | Severe pain at rest | EMERGENCY

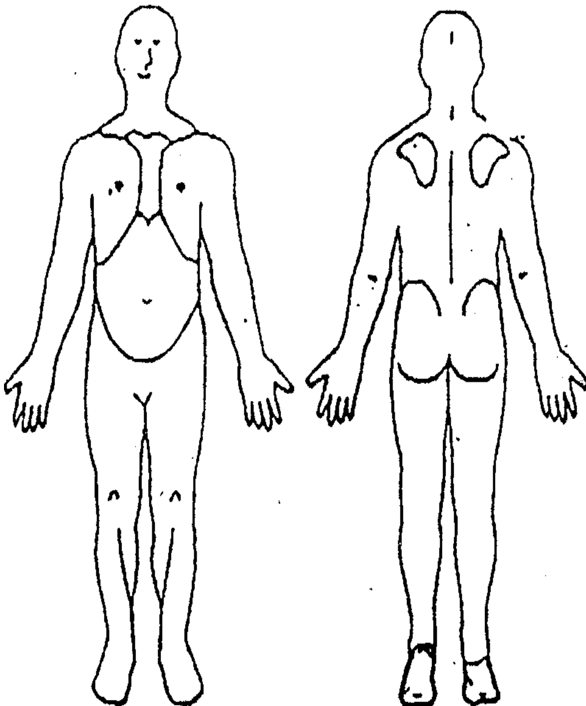
Stiffness: Y / N Numbness & Tingling: Y / N Burning: Y / N Weakness: Y / N

Other (Briefly explain): ____

What medications are you taking ? (List all)____

Any allergies to medications? ____

Mark the body chart to show where your problem is.



Since the problem began have the symptoms become:

Better: ______ Worse: ________ The same: _________

Have the symptoms changed locations? Yes: ____ No: ____

Are you off work because of this problem? Yes: ___ No: ___

Is this a new problem (one you've never had before)?

Yes: ___________ No: ___________

If NO, when did you have this problem before? __________

Was it resolved? Yes: ___________ No: _____________

If Yes, how was it resolved? __________________________

Do your symptoms increase when you cough or sneeze?

Yes: _________ No: __________

How helpful is medication? Very Helpful:__________
Somewhat Helpful: _________ Not at all: _________

(over)

What makes your symptoms worse? ____

What eases your symptoms? ____

Are you having difficulty sleeping through the night? Yes: ___________ No: _____________

If so what wakes you? _________________________How many times do you wake? _____________

Have you received physical therapy for this current problem before today? Yes: ______ No: __________

If yes, when? _____________Where? _________________________ Was it helpful? __________________

How is your general health? (circle one) Excellent Good Fair Poor
Height: ______________________ Weight: _______________

Do you have any medical problems or conditions we need to be aware of? (please circle): pacemaker, cancer, diabetes, pregnancy, bowel/bladder problems, depression, osteoporosis, asthma/lung problems, cardiac problems

Other problems not listed above:____
Any history of recent falls? Yes No If yes, when? ________ Any injury associated with the fall? ___________

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	**I had/have**	**When**	**Family (Specify)**	**When**
Arthritis	______	___________	_________________	________
Lumbago	______	___________	_________________	________
Rheumatism	______	___________	_________________	________
Back Problems	______	___________	_________________	________
Neck Problems	______	___________	_________________	________
Sprain/Strain	______	___________	_________________	________
Headaches	______	___________	_________________	________
Hand Problem	______	___________	_________________	________
Jaw Pain	______	___________	_________________	________
Knee Pain	______	___________	_________________	________
Hip Pain	______	___________	_________________	________
Ankle Pain	______	___________	_________________	________
Scoliosis	______	___________	_________________	________
Stroke	______	___________	_________________	________
Other ___________________	______	___________	_________________	________

Do you have any metal plates, implants or screws? Yes: ____ No: ____ If Yes, please list:_________________

Have you had X-rays or an MRI related to this problem? Yes: _____ No: _____
If Yes, Date/Facility: ____
What do you hope to achieve through physical therapy? What are your goals? _____________________________
____

Thank you for this information, it will make your evaluation process easier.

Patient Signature: ____ **Date:**__________________