MEDICAL HEALTH HISTORY

1. Have you had treatment for this/these problems before? Yes No
   If yes, where and when were you treated for physical therapy? ____________________
   (Hospital or skilled nursing facility) ____________________
   Have you had surgery related to this/these problems? Yes No
   If yes, what type of surgery did you have and when was the surgery?
   ____
2. Have you had any injections for your current problem? Yes No If yes, Location: __________
3. Do you currently have any metal implants? Yes No
4. Do you have a pacemaker? Yes No
5. Do you have any communicable diseases? Yes No
6. Are you pregnant? Yes No
   If so, how many months? __________
7. List any medications you are currently taking:
   ____
   ____
8. In general, would you say your overall health right now is (Circle one):
   Excellent Very Good Good Fair Poor

DESCRIPTION OF SYMPTOMS

Date of injury or onset of symptoms: ____________________

Describe how your injury occurred or when/how your symptoms began:

____

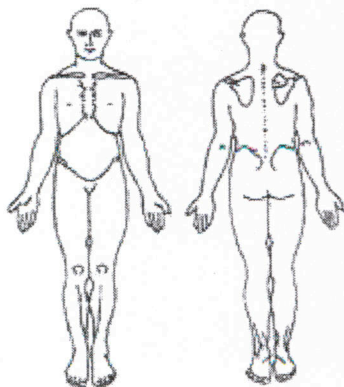
____

Current complaint:

____

____

Please indicate on the diagram where you experience your pain/symptoms:



My pain is increased by:

____

My pain is decreased by:

____

Type of pain: shooting burning aching sharp dull tingling other: ______________

When do you experience your pain/symptoms?

____ Times/Week AM/PM With activity:__________

The frequency of your symptoms are:

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

How are you symptoms changing?

Getting better Not changing Getting worse

During the past 4 weeks, the most severe intensity of your symptoms were:

1 2 3 4 5 6 7 8 9 10

Descriptions of functional limitations and goals:

What activities in your daily life are affected the most by your current complaint, including recreational/social activities, functional activities, and work around the house?

____

If you have limitations/restrictions at your job, what are they?

____

How much has the pain interfered with your work?

Not at all A little bit Some of the time A little of the time None of the time

What are your goals for the first two weeks?_______________________________________

What are your goals at 6-8 weeks?_______________________________________

____ ____________________

Patient/Patient Representative's signature Date

PATIENT NAME: ____ DATE OF BIRTH: _____/_____/_____

MEDICAL HISTORY

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Allergies	O Yes	O No	Depression	O Yes	O No	Multiple Sclerosis	O Yes	O No
Anemia	O Yes	O No	Diabetes	O Yes	O No	Osteoporosis	O Yes	O No
Anxiety	O Yes	O No	Dizzy Spells	O Yes	O No	Parkinsons	O Yes	O No
Arthritis	O Yes	O No	Emphysema/Bronchitis	O Yes	O No	Rheumatoid Arthritis	O Yes	O No
Asthma	O Yes	O No	Fractures	O Yes	O No	Seizures	O Yes	O No
Cancer	O Yes	O No	Gallbladder Problems	O Yes	O No	Strokes	O Yes	O No
Cardiac Conditions	O Yes	O No	Hepatitis	O Yes	O No	Thyroid Disease	O Yes	O No
Cardiac Pacemaker	O Yes	O No	High Blood Pressure	O Yes	O No	Tuberculosis	O Yes	O No
Chemical Dependency	O Yes	O No	Incontinence	O Yes	O No	Vision Problems	O Yes	O No
Circulation Problems	O Yes	O No	Kidney Problems	O Yes	O No			
Currently Pregnant	O Yes	O No	Metal Implants	O Yes	O No			

Describe any other conditions or precautions:

Fall History

Injury as a result of a fall in the past year? O Yes O No **Date of Fall:_______________________**
Two or more falls in the last year? O Yes O No **Dates of Falls:_______________________**

Surgical History

Body Region: _________________ **Surgery Type:** ____________________ **Date of Surgery:**__________
Body Region: _________________ **Surgery Type:** ____________________ **Date of Surgery:**__________
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Body Region: _________________ **Surgery Type:** ____________________ **Date of Surgery:**__________
Body Region: _________________ **Surgery Type:** ____________________ **Date of Surgery:**__________

Current Medications

Drug: ____________________ **Dosage:** ________ **Reason for Taking:**__________________________
Drug: ____________________ **Dosage:** ________ **Reason for Taking:**__________________________
Drug: ____________________ **Dosage:** ________ **Reason for Taking:**__________________________
Drug: ____________________ **Dosage:** ________ **Reason for Taking:**__________________________
Drug: ____________________ **Dosage:** ________ **Reason for Taking:**__________________________