PATIENT MEDICAL HISTORY FORM

Patient Name: _____ Referring Physician: _____

Date of Birth: _____ Date of 1st Doctor Visit for this Injury: _____

Last Date Worked Due to this Injury (if applicable): _____ Date Returned to Work (if applicable): _____

Have you retained an attorney as a result of your injury? **YES** **NO**

Referral Source: Surgeon Rehab MD Direct Access Other: _____

Have you had Surgery for this Injury? **YES** **NO** Number of Surgeries: _____

Date and Type of Surgery(s):_____

Are you currently taking any medications?	YES	NO
Prescription?	YES	NO
Over the Counter?	YES	NO
Herbals?	YES	NO
Vitamin/Mineral/Dietary Supplement?	YES	NO
Other?	YES	NO

If you answered "YES" to any of the medication questions above, please fill out below:

Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____
Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____
Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____
Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____
Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____
Medication Name: _____	Dosage: _____	Frequency: _____	Route: _____

Please utilize "Extra Notes" section at the end of this form if other medications need to be listed.

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
X-Rays	____	____	MRI	____	____
Orthopedist	____	____	Neurologist	____	____
Occupational Therapy	____	____	Physical Therapy	____	____
Podiatrist	____	____	Massage Therapy	____	____
Emergency Room	____	____	Other: _____	____	____

Do you have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma/Bronchitis/Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath/Chest Pain	____	____	Vision/Hearing Difficulties	____	____
Coronary Artery Disease or Angina	____	____	Numbness or Tingling	____	____
Pacemaker	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Bowel or Bladder Problems	____	____
Heart Attack or Surgery	____	____	Weakness	____	____
Stroke/TIA	____	____	Weight/Energy Loss	____	____
Congestive Heart Disease	____	____	Hernia	____	____
Blood Clot/Emboli	____	____	Varicose Veins	____	____
Epilepsy/Seizures	____	____	Allergies	____	____
Thyroid Disease or Goiter	____	____	Anemia	____	____
Any Pins or Metal Implants	____	____	Joint Replacement	____	____
Infections Disease(s)	____	____	Neck Injury/Surgery	____	____
Diabetes	____	____	Shoulder Injury/Surgery	____	____
Cancer or Chemo/Radiation	____	____	Arm/Hand Injury/Surgery	____	____
Arthritis	____	____	Back Injury/Surgery	____	____
Osteoporosis	____	____	Hip/Knee Injury/Surgery	____	____
Gout	____	____	Ankle/Foot Injury/Surgery	____	____
Sleeping Problems	____	____	Are You Pregnant?	____	____
Emotional/Psych Problems	____	____	Do You Use Tobacco?	____	____
Have You Fallen in the Past Year?	____	____	If Yes, How Many Times? _____		

Extra Notes - Please list any additional information/notes that would assist us in providing care to you:

_____

_____

_____

_____

Are you aware of your diagnosis (what you are being treated for)? **Yes** **No**

What are your expectations/goals with participation in physical therapy?

_____

_____

_____

By my signature below, I certify that the information I have provided within this medical history form is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ Date: _____

Patient/Legal Guardian Name: _____

Therapist's Signature: _____ Date: _____