Medical History Form

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

Last Name: _____**First Name**: _____**Date:** _____

Treatment Side: Right Left Both

If accident, circle place where occurred: Home Auto Work Sports Other_____

Do you have any restrictions given by the doctor? Y / N If yes please explain: _____

What is the reason for your visit today? _____

_____

Briefly describe how your problem began: _____

Date of onset/injury:____/____/____ **Date of surgery:**____/____/____ **Type of Surgery:** _____

Circle if Applies: Chronic Sudden Onset Gradual Onset New Injury Aggravation of old injury

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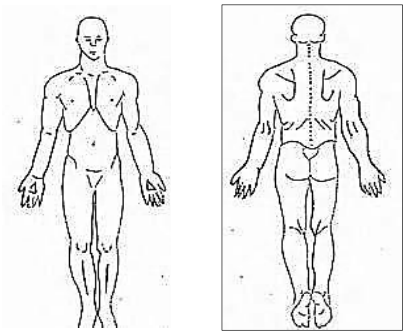
Please circle where you hurt:



Describe pain: burning sharp dull/achy throbbing shooting numbness/tingling constant intermittent worse in AM worse in PM

other: _____

What makes it worse? _____

What makes it better? _____

Does pain wake you from sleep? yes no

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):

Least: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Present: 0 1 2 3 4 5 6 7 8 9 10

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Do you have a history of similar symptoms: yes no

Previous treatment for symptoms:

Physical Therapy Chiropractic Injections Massage Surgery Other:_____

General Health: Good Fair Poor Other:_____

History of Falls: Yes No

Revive Physical Therapy

Work Information: Name of Occupation and Description: _____

please circle: full time part time light duty other:_____

duty level: sedentary light medium heavy very heavy

Past Medical History: Please check any condition you have:

- ❑ No known significant medical history to affect treatment
- ❑ Osteoarthritis
- ❑ Cardiovascular Disease: Pacemaker High/Low Blood Pressure Heart Attack Other:_____
- ❑ Neurological Conditions: Seizures/Epilepsy Stroke Other:_____
- ❑ Pulmonary Conditions: Asthma Emphysema Chronic lung problem Other: _____
- ❑ Diabetes Mellitus: type1 type2
- ❑ Fibromyalgia
- ❑ Osteoporosis
- ❑ Headaches
- ❑ Dizziness
- ❑ Bowel or Bladder Dysfunction
- ❑ Current or Possible Pregnancy
- ❑ Allergies: _____
- ❑ Active or History of Cancer: _____
- ❑ Surgical History: _____
- ❑ Current Infection: _____
- ❑ Other: _____

Have any diagnostic tests have been performed for this problem? (circle all that apply)

X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Blood work Other:

Have you experienced any sudden or unexplained weight loss? yes no

List All Medications or Supplements you are taking:

Medicare Patients: Please provide a complete list of medications including dosage, frequency, route of administration, and reason.

_____

_____

_____

What are your goals to achieve through Physical Therapy? _____

To the best of my ability, I have given and included all pertinent medical information.

Patient/guardian signature: _____ Date: ___/_____ /

Medical history reviewed by physical therapist and used in determining the plan of care.

Therapist signature: _____Date: ____/ ___/ ___