



**PATIENT MEDICAL HISTORY**

Date: \_\_\_\_\_

Patient's Name: \_\_\_\_\_  
Age: \_\_\_\_\_ Occupation: \_\_\_\_\_ Left or Right handed (circle)  
Family Physician: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_  
How did you hear about us? M.D. \_\_\_\_\_ Friend/Name \_\_\_\_\_ Other \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

If accident, place where occurred: Home Work Auto Other \_\_\_\_\_

Briefly describe what happened and/or what is bothering you: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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On a scale from 0 (no pain) to 10 (severe pain) please rate your pain level: \_\_\_\_\_

What makes you symptoms better? \_\_\_\_\_

What makes your symptoms worse? \_\_\_\_\_

Have you been treated previously for this condition? Yes No

Where? \_\_\_\_\_ When? \_\_\_\_\_

Are you currently taking any medications? Please circle: YES NO

Please list: \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies to any medications? Please circle: YES NO

Please list: \_\_\_\_\_  
\_\_\_\_\_

Please list all past surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What type of testing have you had for this condition?

Please Circle: X-Ray MRI CTScan Bone Scan

Other - If yes explain results:

\_\_\_\_\_  
\_\_\_\_\_

Do you exercise regularly? Please circle: Yes No

If yes, what is your primary activity? \_\_\_\_\_

Person to contact in case of an emergency if no one is at your home phone number:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_



**Check appropriate history of past/present conditions:**

Heart Condition	YES__	NO__	Tuberculosis	YES__	NO__
High Blood Pressure	YES__	NO__	Hepatitis/Liver	YES__	NO__
Circulation	YES__	NO__	Kidney or Bladder	YES__	NO__
Phlebitis/Blood Clots	YES__	NO__	Mental or Emotional	YES__	NO__
Asthma or Emphysema	YES__	NO__	Lyme disease	YES__	NO__
Diabetes	YES__	NO__	Cancer	YES__	NO__
Thyroid	YES__	NO__	Arthritis	YES__	NO__
Epilepsy/Seizure/Convulsions	YES__	NO__	Ulcer or Gastrointestinal	YES__	NO__
Stroke	YES__	NO__	Drug/alcohol addiction	YES__	NO__
Pacemaker	YES__	NO__	Nicotine/caffeine addiction	YES__	NO__
Broken/fractured bones	YES__	NO__	Hypoglycemia	YES__	NO__
Low back, hip, leg pain	YES__	NO__	Pregnancy (current)	YES__	NO__
Neck, shoulder, arm pain	YES__	NO__	Allergies/skin allergies	YES__	NO__
Jaw pain/TMJ	YES__	NO__	Herpes/shingles	YES__	NO__
Headaches/head injuries	YES__	NO__	Tendonitis/bursitis	YES__	NO__
Sinus problems	YES__	NO__	Hypoglycemia	YES__	NO__
Sprains/strains	YES__	NO__	Aids/HIV	YES__	NO__
Fatigue	YES__	NO__	Thyroid problems	YES__	NO__

**What are your goals for physical therapy?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Parent or Guardian signature if minor:** \_\_\_\_\_ **Date:** \_\_\_\_\_