

PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: _____ DOB: _____

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.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

High Blood Pressure Abnormal Bleeding Bowel or Bladder Problems
 Heart Problem Asthma Autoimmune disorder
 Diabetes Angina (chest pain) Cancer (location) _____
 Shortness of breath Seizures/Epilepsy Osteoporosis
 Dizziness Arthritis Other: _____

Do you smoke? YES NO _____

Do you exercise regularly? YES NO How often? _____

Do you have any known allergies? YES NO Please list _____

Are you allergic to latex? YES NO

Are you pregnant or suspect pregnancy? YES NO

MEDICATIONS: (Please list name of medications you are currently taking)

SURGERIES: Please list all surgeries, including date:

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

X-rays CT scan MRI Bone Scan EMG Bone Density
 Blood Chemistry Ultrasound other (please specify) _____

Have you seen anyone else for your current problem?

Physician /MD Chiropractor Podiatrist Orthopedic Surgeon Dentist
 Neurologist /Neurosurgeon Osteopath/DO Physical Therapist

CHIEF COMPLAINT/ CURRENT CONDITIONS:

Please describe: _____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities? YES NO

Do you have any weakness in your arms or legs? YES NO

Do you have any coordination or balance problems? YES NO

Do you have difficulty walking? YES NO

Do you experience dizziness or vertigo with a change in position? YES NO

Have you experienced headaches as a result of your condition? YES NO

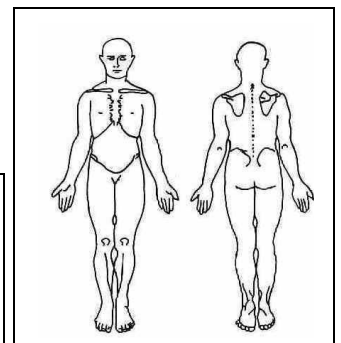
Have you had this problem before? YES NO

Please rate your pain in this scale

(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain)

I believe all information to be true and complete:

Indicate the type of Pain on diagram.
A =Ache B=Burn N=Numb
S=Stabbing P=Pins & Needles



Referring Provider _____ Address _____

Signature _____ Date: _____