CONTACT PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Patient Name: _____ Onset date of illness/injury: _____

Is this injury related to a motor vehicle accident? Yes No Primary Care Physician _____

Referring Physician: _____ Follow-up Visit Scheduled Date: _____

Have you had surgery for this condition? Yes No Number of surgeries: _____

Type of surgery: _____

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-inflammatory _____ List of Medications: _____
Muscle Relaxers _____ (include dosage and _____
Pain Medication _____ frequency & route) _____

Please check if you have had any of the following medical/rehabilitative services for this injury/condition:

- ☐ CT Scan
- ☐ EMG/NCV
- ☐ MRI
- ☐ Myelogram
- ☐ X-Ray
- ☐ Other Diagnostic Test: _____
- ☐ Chiropractor
- ☐ Emergency Room Care
- ☐ General Practitioner
- ☐ Massage Therapy
- ☐ Neurologist
- ☐ Occupation Medicine Doctor
- ☐ Occupational Therapy
- ☐ Orthopedist
- ☐ Physical Therapy
- ☐ Podiatrist
- ☐ Other: _____

Please check if you have a history of any of the following:

- ☐ Anemia
- ☐ Asthma/Bronchitis/Emphysema
- ☐ Blood Clot/Emboli
- ☐ Cancer or Chemo/Radiation
- ☐ Diabetes
- ☐ Emotional/Psychological Problems
- ☐ Epilepsy/Seizures
- ☐ Heart Attack or Heart Surgery
- ☐ Heart Disease or Angina
- ☐ High Blood Pressure
- ☐ Infectious Disease
- ☐ Pacemaker
- ☐ Shortness of breath/chest pain
- ☐ Sleeping Problems/Disorders
- ☐ Stroke/TIA
- ☐ Thyroid Trouble/Goiter
- ☐ Tuberculosis
- ☐ Allergies
- ☐ Bowel or Bladder Problems
- ☐ Dizziness or Fainting
- ☐ Hernia
- ☐ Numbness or Tingling
- ☐ Severe or Frequent Headaches
- ☐ Varicose Veins
- ☐ Vision or Hearing Difficulties
- ☐ Weakness
- ☐ Weight Loss/Energy Loss
- ☐ Any Pins or Metal Implants
- ☐ Arthritis/Swollen Joints/Gout
- ☐ Back Injury/Surgery
- ☐ Elbow/Hand Injury/Surgery
- ☐ Joint Replacement
- ☐ Knee Injury/Surgery
- ☐ Leg/Ankle/Foot Injury/Surgery
- ☐ Neck Injury/Surgery
- ☐ Osteoporosis
- ☐ Shoulder Injury/Surgery

Are you pregnant? Y N

Have you had 2 or more falls in the last year or any fall with injury in the last year? Y N

Height _____ Weight _____

Is there any other information that you feel would assist us in your care? _____

_____

Are you aware of what your diagnosis is? Yes No

What are your goals while in this program? _____

Patient/Guardian Signature: _____ **Date:** _____

I have reviewed this medical history with the patient: _____
Therapist Signature