

## MEDICAL HISTORY

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

How did your problem begin?  Trauma or Fal  I Had Surgery  No Apparent Reason

When did your problem begin? \_\_\_\_\_

Describe the incident \_\_\_\_\_

Describe your current symptoms:

Pain level (circle) (None) **0 1 2 3 4 5 6 7 8 9 10** (Severe)

Stiffness  Swelling  Tingling  Radiating Symptoms  
 Loss of Strength  Loss of Sensation  Loss of Balance / Falls– How Many in the Past Year? \_\_\_\_\_

What helps relieve the pain? \_\_\_\_\_

What activities are limited or painful due to your condition?

- |                                   |                                    |  |   |  |
|-----------------------------------|------------------------------------|--|---|--|
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Stairs    | <input type="checkbox"/> Reading       | <input type="checkbox"/> Recreation / Sport | <input type="checkbox"/> Bathing / Washing |
| <input type="checkbox"/> Sitting  | <input type="checkbox"/> Lifting   | <input type="checkbox"/> Concentrating | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Bed Mobility      |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Driving   | <input type="checkbox"/> Job Duties    | <input type="checkbox"/> Squatting          | <input type="checkbox"/> Carrying Objects  |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Traveling | <input type="checkbox"/> Housework     | <input type="checkbox"/> Social Life        | <input type="checkbox"/> Reaching Overhead |

Please list any sport or leisure activities you participate in: \_\_\_\_\_

Are your job duties limited due to your condition?  No  Yes  
If Yes, please describe how

\_\_\_\_\_

What is your goal for physical therapy? \_\_\_\_\_

Do you have any of the following conditions?

Check all that apply:

- |  |   |   |  |  |
|--|---|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung Disease     | <input type="checkbox"/> Pregnancy            | <input type="checkbox"/> Seizures / Epilepsy | <input type="checkbox"/> Hip Replacement     |
| <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Allergies        | <input type="checkbox"/> Weight Loss/Gain     | <input type="checkbox"/> Tumors              | <input type="checkbox"/> Knee Replacement    |
| <input type="checkbox"/> Pacemaker           | <input type="checkbox"/> Asthma           | <input type="checkbox"/> Multiple Sclerosis   | <input type="checkbox"/> HIV / AIDS          | <input type="checkbox"/> Other Knee Surgery  |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Mental Illness       | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Shoulder Surgery    |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Problems  | <input type="checkbox"/> Bowel/Bladder Issues | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Back / Neck Surgery |
| <input type="checkbox"/> Other _____         |   |   |  |  |

Comments: \_\_\_\_\_

Please list all medications you are currently taking (prescription and over the counter):

\_\_\_\_\_

\_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_