Physical Therapy & Sports Medicine Center

PATIENT MEDICAL HISTORY

Patient's Name_____ Date of Birth _____/_____/____ Age: _____

Date of Injury or accident___/___/____ Height: _____ Weight: _____

Have you had surgery for this injury? YES NO (If yes, Number of Surgeries____)

Are you currently taking any Prescription or Non- Prescription Medication? YES NO

List Medications:_____

_____

Have you had any of the following Medical or Rehabilitation services for this injury YES NO

	YES	NO		YES	NO
Chiropractor	____	____	Occupacional Therapy	_____	_____
EMG/NVC	____	____	Orthopedic	_____	_____
Massage Therapy	____	____	Physical Therapy	_____	_____
Myelogram	____	____	Podiatrist	_____	_____
ER CARE	____	____	X Rays	_____	_____
CT SCAN	____	____	MRI	_____	_____
Gen Prac.	____	____			
Neurologist	____	____			

Other:

_____

Do you now or have you ever had any of the Following?-

	YES	NO		YES	NO
Asthma, Bronchitis, or emphysema	_____	_____	Severe or Frequent Headaches	____	_____
Shortness of Breath/Chest Pain	_____	_____	Virsion or Hearing Dificulties	____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or Tingling	____	_____
Do you have a Pacemaker?	_____	_____	Dizziness or Fainting	____	_____
High Blood Pressure	_____	_____	Hernia	_____	_____
Heart Attack/Surgery	_____	_____	Blood Clot/Emboli	_____	_____
Stroke/ TIA	_____	_____	Veracose Veins	_____	_____
Bowel or Bladder Problems	_____	_____	Allergies	_____	_____
Epilepsy/Seizures	_____	_____	Pins or Metal Implants	_____	_____
Thyroid Trouble/Goiter	_____	_____	Joint Replacement	_____	_____
Anemia	_____	_____	Diabetes	_____	_____
Infectious Disease	_____	_____	Cancer or Chemotherapy	_____	_____
Emotional/Psychological Problems	_____	_____	Osteoporosis	_____	_____
Arthritis/Swollen Joints	_____	_____	Are you Pregnant?	_____	_____
Gout	_____	_____	Do you Smoke?	_____	_____
Difficulty or unable to sleep	_____	_____	Elbow/Hand/Shoulder Surgery	_____	_____
Leg/ankle/knee/foot Surgery	_____	_____	Weakness	_____	_____
Back/Neck/Surgery	_____	_____			
Have you had any falls in the last year?	_____	_____			

Are you aware of your Diagnosis? YES NO

Based on your awareness, what are your expectations/goals while in this program?

_____

_____

_____

SIGNATURE: _____ DATE: _____/_____/_____

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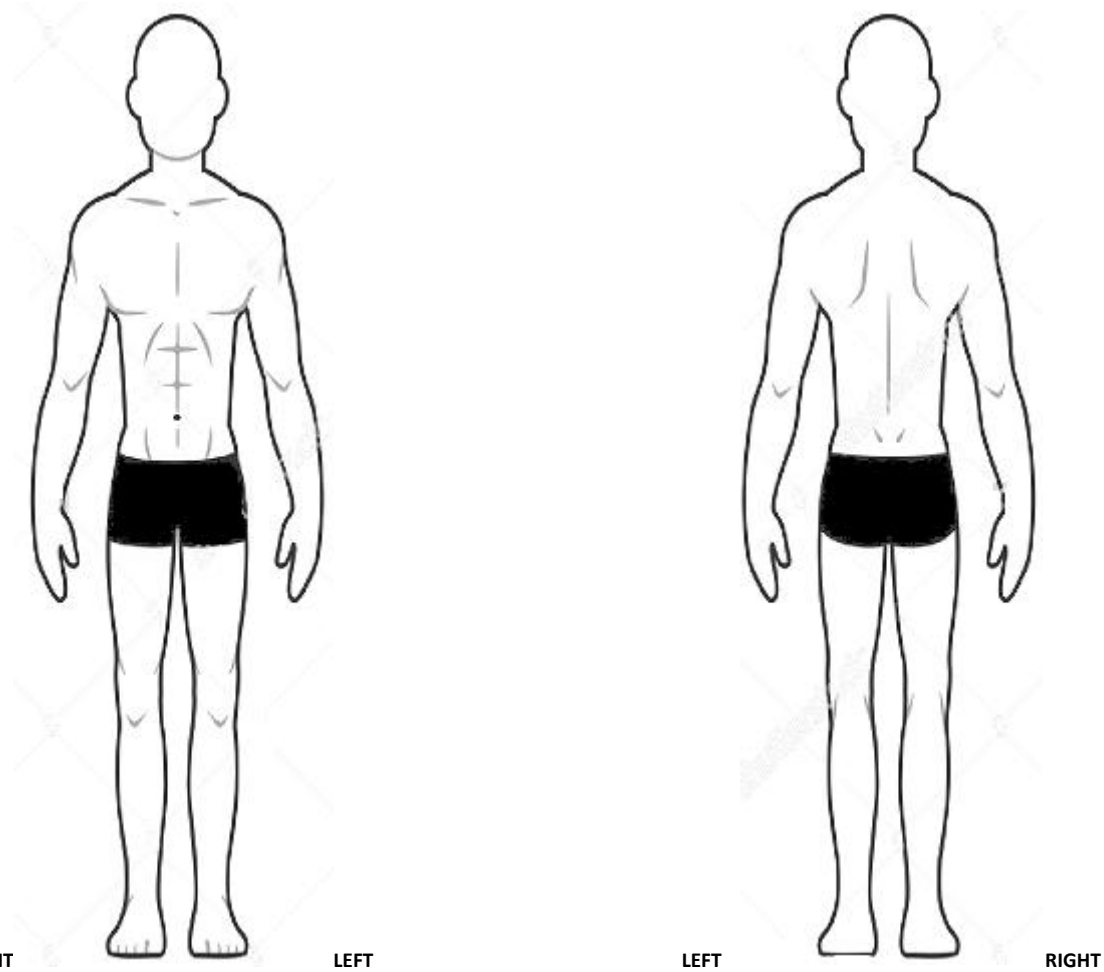
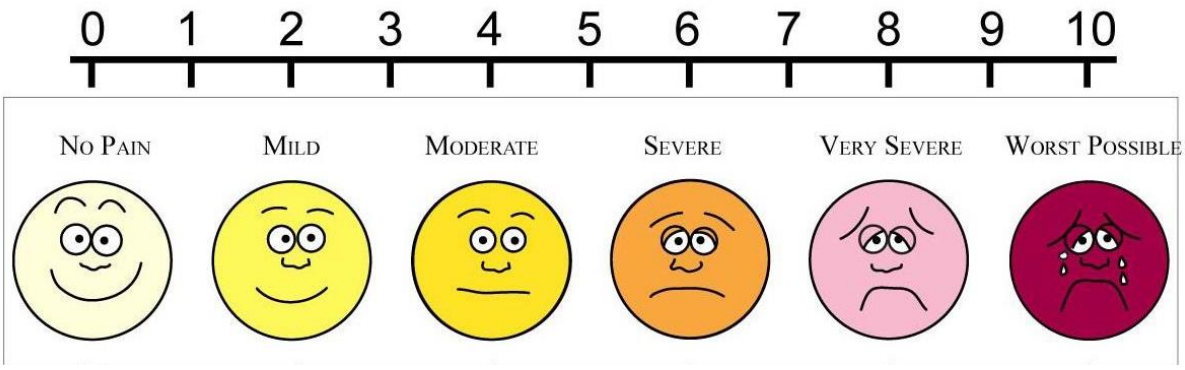
Draw the Location of your pain on the body outlines and circle the pain face that applies:

Pain	Burning	Numbness	Pins & Needles	Stabbing	Other
^^^^^	* * * *	∞∞∞∞	.....	///////	XXX

FRONT **BACK**



RIGHT **LEFT** **LEFT** **RIGHT**



SIGNATURE: _____ DATE: _____/_____/_____