MEDICAL HISTORY FORM

PATIENT NAME: _____ Acct#: _____

Please check if you have been diagnosed with any of the following conditions:

_____Diabetes(I/II)	_____Heart Disease	_____High Blood Pressure	_____Cancer
_____Pacemaker	_____Stroke (TIA or CVA)	_____Seizures	_____Metal Implants
_____Back Pain	_____Circulation problems	_____Osteoporosis	_____Stomach ulcers
_____Broken bones	_____Respiratory Problems	_____Depression	_____Asthma
_____Blood Clots	_____Rheumatoid Arthritis	_____Thyroid Problems	_____Kidney problems

_____Infectious Diseases (HIV, Hepatitis, TB, etc.) _____

_____Other: _____

Surgical History: _____

Have you recently noted? Check all that apply:

_____Nausea/Vomiting	_____Dizziness spells	_____Pain at night	_____Currently pregnant
_____Unusual weakness	_____Visual problems	_____Heart Palpitations	_____Hearing problems
_____Bleeding	_____Difficulty walking	_____Joint pain or swelling	_____**Fever**/chills/sweats
_____Chest Pain	_____**Shortness of breath**	_____Incontinence	_____Productive/Chronic **Cough**
_____Difficulty sleeping	_____Loss of Appetite	_____Unexplained weight changes	_____Fatigue or myalgia

Have you recently traveled from an area with widespread or ongoing community spread of coronavirus? ☐ **Yes** ☐ **No**

Have you had direct prolonged contact with someone with confirmed case of coronavirus? ☐ **Yes** ☐ **No**

How many times have you fallen in the past 12 months? _____ Did it results in an injury? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Please list <u>all</u>, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:

_____

_____

_____

Sex: ☐ Male ☐ Female **Height:** _____ **Weight:** _____

Are you: ☐ Right handed ☐ Left handed

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

With whom do you live:

☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other _____

Where do you live:

☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other_____

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain

Please explain: _____

Employment/Work (Job/School/Play):

☐ Working: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Occupation: _____

PATIENT NAME: _____

General Health Status, Please rate your health; ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of onset of current symptoms/injury: **Month** _____ **Day** _____ **Year** _____

Describe the problem(s) for which you seek therapy: _____

_____

Explain how problem(s) occurred: _____

_____

How are you taking care of the problem(s) now? _____

What makes the problem(s) <u>better</u>? _____

What makes the problem(s) <u>worse</u>? _____

What functions could you perform before, that now you are unable to do? _____

_____

What are your goals for therapy? _____

Have you ever had the problem(s) before? _____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc._____

Have you received X-rays, MRI, CT scan, Bone Scan, etc. for this problem? If so, what were the results

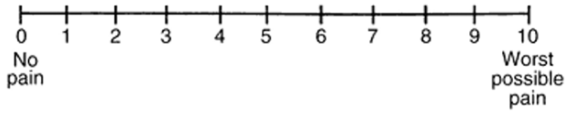
_____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

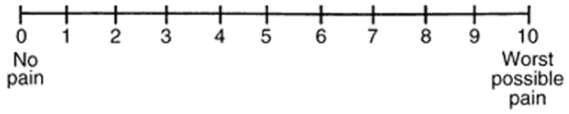
If yes, please tell us what it is: _____

Pain Rating:
If you have pain, what is your pain level? Circle

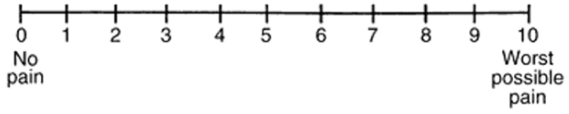
<u>CURRENT</u> Pain



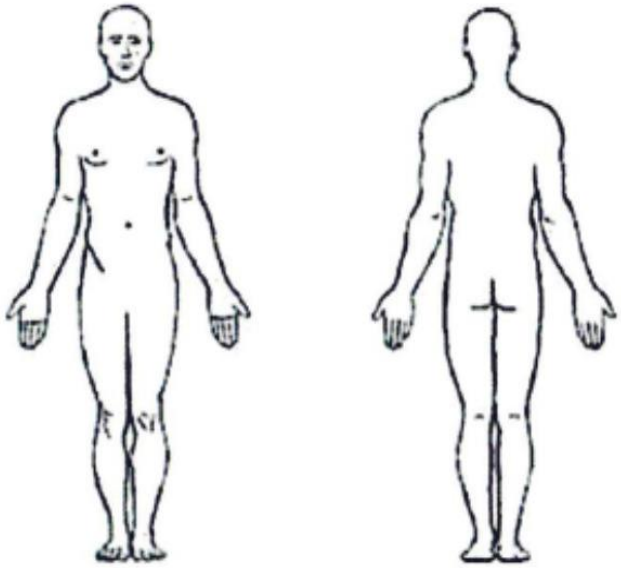
Pain level at **<u>BEST</u>**



Pain level at **<u>WORST</u>**



<u>Please mark the location of pain with an "X"</u>



To the best of my knowledge the above information is accurate and complete.

Patient Signature: _____ **Date:** _____

Therapist signature: _____ Date: _____