



MEDICAL HISTORY

Name: _____ Date: _____

Date of Birth: _____ Occupation: _____

Reason for your visit: _____

Date of Injury/Surgery: _____ Prior History: _____

Have you had previous physical therapy for this condition? / Where?: _____

Have you had any in home physical therapy visits for this condition?: YES / NO Date ended: _____

Doctor's Name: _____ When is your next doctor's appointment? _____

Please describe the injury or onset of this condition: _____

Type of pain: sharp / burning / aching / tingling / numbness / other _____

Rate pain on a 0 – 10 scale: 0=None | | 10=Severe

Does pain radiate into arms and legs: YES / NO Does rest relieve your pain: YES / NO

Does pain awaken you: YES / NO Are you currently taking medications: YES / NO

Medications & conditions: _____

What aggravates your pain most: sitting / standing / walking / other _____

What positions are most comfortable: _____

What other details can you tell us about your injury or condition? _____

Are you currently experiencing or have you experienced any of the following:

Diabetes	YES / NO	Kidney Problems	YES / NO
High Blood Pressure	YES / NO	Nervous Disorders	YES / NO
Heart Arrythmia	YES / NO	Stroke	YES / NO
Heart Disease	YES / NO	Pregnant / IUD	YES / NO
Heart Attack	YES / NO	Allergies / Skin Disorders	YES / NO
Pacemaker	YES / NO	Hernia	YES / NO
Headaches	YES / NO	Metal Implants	YES / NO
Seizures	YES / NO	Shortness of Breath	YES / NO
Cancer	YES / NO	Asthma	YES / NO
Injured in a motor vehicle accident	YES / NO	Unrelated previous surgeries	YES / NO

If yes to any of the above, please explain & give approximate dates: _____