

ProSport Physical Therapy

MEDICAL HISTORY FORM

Patient Name _____ What Body Part are you here for? _____

When did your condition start? Give specific date of injury or onset: _____

Have you had previous Physical Therapy for this condition? Yes / No

Did you have Surgery? Yes / No When? Give Date: _____ what surgery was done? _____

Did you have any of the following tests? X-Ray MRI CT Scan EMG Other _____ When? Give Date: _____

When is your next Doctor's Appointment? Give Date: _____

Are you currently experiencing or have you ever experienced any of the following?

Diabetes	yes () no ()	Hernia	yes () no ()
High Blood Pressure	yes () no ()	Nervous disorders / Depression	yes () no ()
Heart Disease	yes () no ()	Seizure	yes () no ()
Heart Attack	yes () no ()	Allergies / Skin	yes () no ()
Pacemaker	yes () no ()	Headaches/Dizziness	yes () no ()
Heart Murmur/Arrhythmia	yes () no ()	Metal Implants	yes () no ()
Stroke	yes () no ()	Recent Fatigue / Weakness	yes () no ()
Shortness of Breath	yes () no ()	Recent Fever	yes () no ()
Asthma	yes () no ()	Recent Nausea / Vomiting	yes () no ()
Cancer	yes () no ()	Recent Chills / Sweats	yes () no ()
Thyroid Problems	yes () no ()	Recent Weight Gain or Loss	yes () no ()
Kidney Problems	yes () no ()	Injured in a Motor Vehicle Accident	yes () no ()
Infectious Disease / HIV / Hepatitis	yes () no ()	Any previous injury	yes () no ()
Pregnant / IUD	yes () no ()	Previous Surgery	yes () no ()

IF YES on any of the above please give details & approximate dates _____

Are you currently taking MEDICATIONS? Yes / No Please List: _____

Do you have PAIN? IF so DRAW on the BODY CHART where your pain is located→→→→

What does your pain feel like? (✓ All that Apply)

sharp burning aching tingling numbness other _____

Does pain radiate to arms and/or legs? Yes / No

Rate your pain on a 0-10 scale (0=None,10=Severe) 0 1 2 3 4 5 6 7 8 9 10 (circle one)

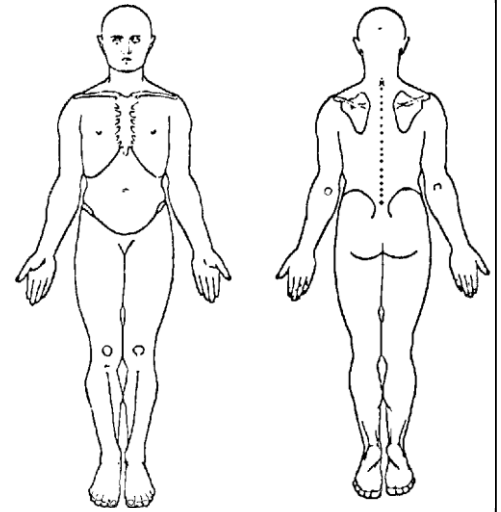
Does pain awaken you at night? No / Yes, if so how many times each night? _____

What makes the pain WORSE? (✓ All that Apply)

Lying down sitting standing walking other _____

What EASES the pain? (✓ All that Apply)

Lying down sitting standing walking other _____



(Mark pain on diagram)

Functional activities Can you drive? Yes / No Can you climb stairs? Yes / No are you able to provide self-care? Yes / No

Leisure Activities: Please List: _____

Is there anything else you want us to know about your condition? _____

Signed: _____ Date: _____