

PATIENT MEDICAL HISTORY FORM

Name: _____ Age: _____

Occupation: _____ Job Duties: _____

Is your problem associated with some accident or injury? Yes: _____ No: _____

If yes, briefly Explain: _____

Date of injury/ onset of symptoms: _____ If applicable, date of surgery: _____

How would you describe your symptoms? _____

PAIN SCALE: 0 1 2 3 4 5 6 7 8 9 10 (0=no pain, 10=severe pain)

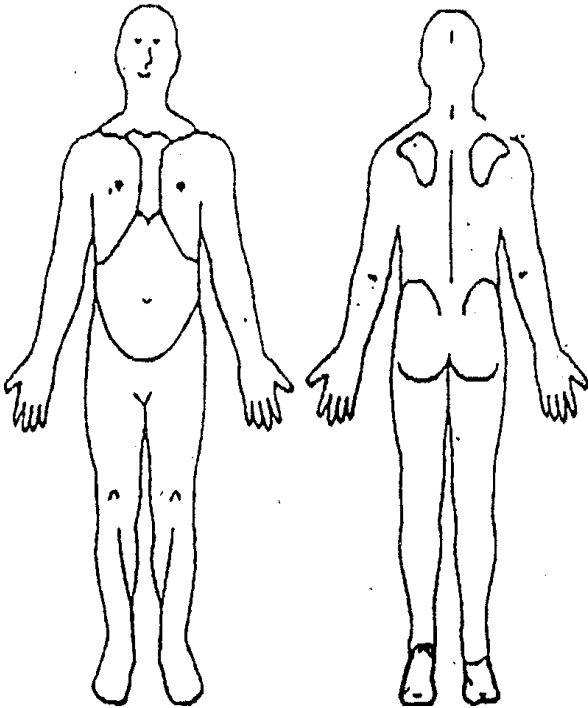
Stiffness: Y / N Numbness & Tingling: Y / N Burning: Y / N Weakness: Y / N

Other (Briefly explain): _____

What medications are you taking ? (List all) _____

Any allergies to medications? _____

Mark the body chart to show where your problem is.



Since the problem began have the symptoms become:

Better: _____ Worse: _____ The same: _____

Have the symptoms changed locations? Yes: _____ No: _____

Are you off work because of this problem? Yes: _____ No: _____

Is this a new problem (one you've never had before)?

Yes: _____ No: _____

If NO, when did you have this problem before? _____

Was it resolved? Yes: _____ No: _____

If Yes, how was it resolved? _____

Do your symptoms increase when you cough or sneeze?

Yes: _____ No: _____

How helpful is medication? Very Helpful: _____

Somewhat Helpful: _____ Not at all: _____

(over)

Are you having difficulty sleeping through the night? Yes: _____ No: _____

If so what wakes you? _____ How many times do you wake? _____

What makes your symptoms worse? _____

What eases your symptoms? _____

Have you received physical therapy for this current problem before today? Yes: _____ No: _____

If yes, when? _____ Where? _____ Was it helpful? _____

How is your general health? (circle one) Excellent Good Fair Poor

Do you have any medical problems or conditions we need to be aware of? (please circle): pacemaker, cancer, diabetes, pregnancy, bowel/bladder problems, depression, osteoporosis, asthma/lung problems, cardiac problems

Other problems not listed above: _____

Any history of recent falls? Yes No If yes, when? _____ Any injury associated with the fall? _____

Some illnesses and conditions are genetically transferred. It is useful for us to know what conditions you or your family members have or have had in the past. Please tell us:

Condition	I had/have	When	Family (Specify)	When
Arthritis	_____	_____	_____	_____
Lumbago	_____	_____	_____	_____
Rheumatism	_____	_____	_____	_____
Back Problems	_____	_____	_____	_____
Neck Problems	_____	_____	_____	_____
Sprain/Strain	_____	_____	_____	_____
Headaches	_____	_____	_____	_____
Hand Problem	_____	_____	_____	_____
Jaw Pain	_____	_____	_____	_____
Knee Pain	_____	_____	_____	_____
Hip Pain	_____	_____	_____	_____
Ankle Pain	_____	_____	_____	_____
Scoliosis	_____	_____	_____	_____
Stroke	_____	_____	_____	_____
Other _____	_____	_____	_____	_____

Do you have any metal plates, implants or screws? Yes: _____ No: _____ If Yes, please list: _____

Have you had X-rays or an MRI related to this problem? Yes: _____ No: _____

If Yes, Date/Facility: _____

What do you hope to achieve through physical therapy? What are your goals? _____

Thank you for this information, it will make your evaluation process easier.

Patient Signature: _____ **Date:** _____