Medical History Form

ADVANCED PHYSICAL THERAPY and Sports Rehab
Therapy with a heart!

Name: _____ Date: _____

Is this injury related to (select): ☐ Work ☐ Motor Vehicle Accident ☐ Recurrent (Prev. Injury)

☐ Recreational Injury ☐ Athletic Injury ☐ Fall ☐ Other _____

Please rate your pain intensity (0=no pain, 10=worst pain) Most: ____ Least: ____ Current: ____

Please describe your pain (select): ☐ Numbness ☐ Pins & Needles ☐ Burning ☐ Aching ☐ Stabbing

☐ Grinding ☐ Stiffness ☐ Cramps ☐ Throbbing ☐ Dull ☐ Constant ☐ Intermittent ☐ Other_____

When did your pain begin? _____

Pain Onset: ☐ Gradual ☐ Sudden

What makes your pain worse? _____

What makes your pain better? _____

Have you had these symptoms before? _____

If you see another health professional for this problem, may the physical therapist discuss your case with him or her?
☐ Yes ☐ No

Medical History Form

1. Within the past year, have you had any of the following medical test?

☐ Angiogram
☐ Arthroscopy
☐ Biopsy
☐ Bone scan
☐ CT scan
☐ Doppler ultrasound
☐ Echocardiogram
☐ EKG (electrocardiogram)
☐ EMG (electromyogram)
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Pulmonary function test
☐ Stress test (such as treadmill, bicycle)
☐ X-rays

2. Within the past year, have you had any of the following symptoms?

☐ Chest pain
☐ Coordination problems
☐ Chronic cough
☐ Difficulty sleeping
☐ Dizziness/blackouts
☐ Fever/chills/sweats
☐ General malaise
☐ Headaches
☐ Heart palpitation
☐ Loss of appetite
☐ Loss of balance/falls
☐ Nausea/vomiting
☐ Pain during the night
☐ Sexual dysfunction
☐ Shortness of breath
☐ Vision problems
☐ Weakness in arms or legs
☐ Weight loss/gain

3. Are you pregnant or think you might be pregnant? ☐ Yes ☐ No

4. Do you live alone? ☐ Yes ☐ No

5. Does your home have:
☐ Stairs ☐ Elevator ☐ Ramps

6. Do you use:
☐ Cane ☐ Walker ☐ Other _____

7. Are you: ☐ Right-handed ☐ Left-handed

8. Do you Smoke? ☐ Yes ☐ No

9. Employment
☐ Work outside of home
☐ Homemaker
☐ Unemployed
☐ Retired
☐ Occupation _____

How many hours do you spend at a computer/desk per day? _____
How much and how often do you lift objects heavier than 10 pounds?
# of times/day: _____
Average weight of objects lifted: _____

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(Continued)

Please check mark all conditions that you have, or have had in the past.

Musculoskeletal
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Lupus/SLE
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Headaches/Migraines
- ☐ Bulging Disc
- ☐ Leg Cramps/Restless Legs
- ☐ Jaw Pain/TMJ
- ☐ History of falling
- ☐ Use of cane or walker
- ☐ Gout
- ☐ Sprain/Strain
- ☐ Fracture/Dislocation
- ☐ Other: _____

Nervous System
- ☐ Stroke/TIA
- ☐ Polio
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Epilepsy/Seizures
- ☐ Concussion/TBI
- ☐ Numbness or Tingling
- ☐ Other: _____

Cancer

Type of Cancer: _____

Where: _____

Date of Diagnosis: _____

Treatments: _____

Skin
- ☐ Skin Allergies/rashes

Psychological
- ☐ Depression
- ☐ Anxiety disorder
- ☐ Bipolar disorder
- ☐ Schizophrenia
- ☐ Obsessive compulsive disorder
- ☐ Other: _____

Infectious Disease
- ☐ TB
- ☐ Hepatitis
- ☐ Influenza
- ☐ Shingles
- ☐ Other _____

Circulation/Respiratory
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Arrhythmia
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Blood Clots/Phlebitis
- ☐ Anemia
- ☐ High Blood Pressure
- ☐ Asthma/SOB
- ☐ COPD
- ☐ Other: _____

Endocrine/Digestion
- ☐ Diabetes
- ☐ Kidney Dysfunction
- ☐ Irritable Bowel
- ☐ Bladder Dysfunction
- ☐ Liver Dysfunction
- ☐ Thyroid Dysfunction
- ☐ Hernia
- ☐ Other: _____

Please list any surgeries you have had: _____

_____

What are your personal goals for Physical Therapy? _____

MEDICATION/ALLERGIES INFORMATION

Medicine ALLERGIES & Reaction: _____

_____

Current Medications (both Prescription and Over-The Counter):

Medication Name	Dosage/Frequency	Route (oral, injections etc.)

Patient's signature: _____ Date: _____

Parent or Guardian signature: _____ Date: _____

I have reviewed any contraindications and their rehabilitation protocol with the named patient or the appropriate caregiver prior to initiating evaluation and treatment.

Therapist's Signature: _____ Date: _____