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physical therapy, P.C.

Patient Medical History Form

Patient Information

Patient Name:______________________________________ Date: _______________________

Address:____

Email Address: ____

Phone Number: _________________________________ Date of Birth: _______________________

Emergency Contact/Phone #: ____

Referring Physician (if applicable):____

Occupation:____

Injured Body Part:____

Is this the result of a work or car accident? ____

How long have you had this injury?____

Have you ever been to Physical Therapy before?____

Have you had surgery on this body part, if so when?____________________________________

How did you hear about us? ____

Have you had any of the following for this injury (please circle):

MRI   X-Ray   CT Scan   EMG   Injection

Are you currently being treated by any other health care professionals (please list):

____

____

Please list all medications (prescribed and over the counter) that you are currently taking:

Type/Dosage:__________________________ Type/Dosage:__________________________

Type/Dosage:__________________________ Type/Dosage:__________________________

Type/Dosage:__________________________ Type/Dosage:__________________________

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Do you have any of the following conditions:

Please Check:	Yes	No		Yes	No
High Blood Pressure			Skin Conditions		
Heart Problems/Pacemaker			Osteoporosis		
Cancer			Vascular Problems		
Osteoarthritis			Headaches		
Rheumatoid Arthritis			Depression		
Diabetes			Thyroid Problems		
Stroke or TIA			Gait/Balance Issues		
Epilepsy			Allergies		
Multiple Sclerosis			Fibromyalgia		
Chemical Dependency			Chronic Fatigue Syndrome		
Hepatitis			Kidney Disease		
HIV/AIDS			Nausea/Vomiting		
Infectious Disease			Excessive Weight Gain/Loss		
COPD/Bronchitis			Fever/Chills		
Asthma			Fatigue		
Joint Replacement			Pregnant		
Other:					

List any surgeries:____

____

How many caffeinated drinks do you have per day?___________________________________

How many packs of cigarettes do you have per day?__________________________________

How many alcoholic beverages do you drink per week?_______________________________

Please list three activities that you are limited with due to your injury:

1. ____
2. ____
3. ____

Patient/Guardian Signature:______________________________ Date:________________

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Pain Explanation:

What are your current complaints?____

Level of Pain (0-10, 10 being worst pain) please circle:

Current: 0 1 2 3 4 5 6 7 8 9 10

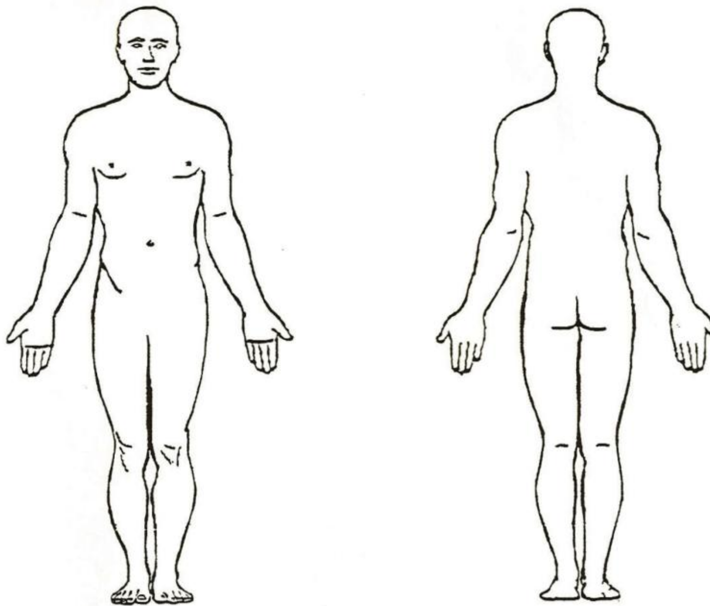
At Rest: 0 1 2 3 4 5 6 7 8 9 10

With Activity: 0 1 2 3 4 5 6 7 8 9 10

Describe the type of pain (please circle):

Dull Ache Burning Numbness/Tingling Throbbing Sharp

Please use the below diagram to show the area of your pain/injury:



Patient/Guardian Signature:_____________________________ Date:______________

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