



Patient Medical History Form

MEDICAL HISTORY / SUBJECTIVE INFORMATION

Name: _____ Date: ___/___/___ Birthdate: ___/___/___ Age: _____
Height: _____ Weight: _____ Referring Physician: _____

Medical History: (Please check all that apply)

- | | | | |
|--|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Visual Impaired | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> HIV /AIDS | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Impaired | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Asthma | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnant | <input type="checkbox"/> [Add] |

Therapist's comments: _____

Have you had physical therapy for this condition in the past? Y N Was it effective? Y N

Are you currently receiving other treatments for this condition (eg. Chiropractor, Acupuncture)? Y N

Have you had surgery for your condition? Y N If yes, please give approximate date: _____

Have you had any injections for your condition? Y N If yes, please give approximate date: _____

Please list any diagnostic tests you have had for this condition: _____

Please list any **medications** that you are taking: _____

What are your current symptoms? _____

When did the injury or symptoms occur?

First episode: _____ Second episode: _____ Third episode: _____

How the injury or problem occur? _____

Please rate your pain using a 0 – 10 scale (0 = no pain, 10 = the worst pain you can imagine)

Worst pain since onset: _____ **Best** pain since onset: _____ **Today's** pain: _____

Where is your pain or problem located? _____

Is your pain? Constant Intermittent

What makes your pain / problem **better**? _____ **Worse**? _____

Is there pain present at night? Y N What position helps you to sleep? _____

Therapist's Comments: _____

Would you like to speak to someone regarding abuse or neglect that you have recently experienced? Y N

Employment History:

Are you currently working? Y N If no, how many total days of work have you missed? _____

Are your work duties? Full Restricted How many hours per week do you work? _____

Who is your employer? _____

What type of work do you do? _____

What critical work duties have been most affected by your problem? _____

What do you hope to accomplish with therapy? _____

