



Outpatient Physical Therapy and Rehabilitation Services

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the most accurate, important, and up to date background information

Name: _____ Date: _____

Occupation: _____ Employer: _____

Date of injury or onset: _____ Date of Surgery: _____ Type of Surgery: _____

Briefly describe your symptoms: _____

Dominant side: Right Left Involved side: Right Left

How did your injury occur:

- Work incident Fall Carrying MVA
- Recreation/sports Throwing Pushing Impact injury
- Home injury Trauma Pulling Running
- Degenerative process Lifting Overuse Infection
- Unknown Other: _____

Have you had any of the following tests for this condition?

- Angiogram Doppler ultrasound MRI Stool test
- Arthroscopy Echocardiogram Myelogram Stress test
- Biopsy EEG NVC Stress x-ray
- Blood tests EKG Pap smear Urine test
- Bronchoscopy EMG Pulmonary function test X-rays
- CT scan Mammogram Spinal tab Other: _____

Test Results: _____

Nature of pain/symptoms:

- Aching Numbness & tingling Radiating Throbbing
- Burning Occasional Shooting Other: _____
- Constant Periodic Stabbing
- Dull Pins & needles Sharp

As the day progresses do symptoms: Increase Decrease Stays the same

Do symptoms wake you at night? Yes No

What alleviates your symptoms? (Please check all that apply)

- Coughing/sneezing Moving Stress
- Cold Reaching across body Sustained bending
- Cutting/pivoting Reaching behind back Swallowing
- Exercise Reaching in front of body Taking deep breaths
- Going to/rising from sitting Recreation/sports Talking
- Heat Repetitive activities Chewing
- Kneeling Rest Twisting
- Jumping Sitting Wearing splint/orthotics
- Lying down Sleeping Uneven ground
- Looking overhead Squatting Up/down stairs
- Massage Standing Other: _____
- Medication Stretching

What aggravates your symptoms? (Please check all that apply)

- Coughing/sneezing Moving Stress
- Cold Reaching across body Sustained bending
- Cutting/pivoting Reaching behind back Swallowing
- Exercise Reaching in front of body Taking deep breaths
- Going to/rising from sitting Recreation/sports Talking
- Heat Repetitive activities Chewing
- Kneeling Rest Twisting
- Jumping Sitting Wearing splint/orthotics
- Lying down Sleeping Uneven ground
- Looking overhead Squatting Up/down stairs
- Massage Standing Other: _____
- Medication Stretching

Medications you are currently taking: (Please check all that apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Decongestants | <input type="checkbox"/> Steroids |
| <input type="checkbox"/> Advil/Aleve | <input type="checkbox"/> Tylenol | <input type="checkbox"/> Anticoagulant |
| <input type="checkbox"/> ibuprofen/naproxen | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Relaxants |
| <input type="checkbox"/> antihistamines | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Herbal supplements |

Other: _____

Family History: (Please check all that apply)

- | | | | |
|--|---------------------------------------|--|---------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Psychological | <input type="checkbox"/> Cancer |

Other: _____

Personal Medical History: (Please check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Heart problems |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Parkinson disease |
| <input type="checkbox"/> Low blood sugar/ hydroglycemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Developmental/growth problems | <input type="checkbox"/> Skin disease |
| <input type="checkbox"/> Ulcers/stomach problems | <input type="checkbox"/> Depression | Other: _____ |

Symptoms you have experienced in the past year: (Please check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Weight loss/gain |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Dizziness/blackouts | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Weakness in arms/legs | <input type="checkbox"/> Bowel problems | |

Other: _____

Please list any recent/relevant surgeries or hospitalizations:

_____ Date: _____

_____ Date: _____

_____ Date: _____

Do you smoke? Yes No Packs per day: _____ Cigars/pipes per day: _____

Have you smoked in the past? Yes No Year quit: _____

How many days per week do you consume alcoholic beverages? _____ How many drinks per day? _____

How often do you exercise: 5+ days/week 1-2 days per/week Occasionally Never

What do your athletic/recreational activities entail: _____

Other Providers you have seen for this problem:

- | | | |
|--|--|---|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Neurologist | <input type="checkbox"/> OB/GYN |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Osteopath | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Family practioner | <input type="checkbox"/> Pediatrician | Other: _____ |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Podiatrist | |

Patient Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____