



PATIENT MEDICAL HISTORY

Patient's Name: _____ Date: _____

Age: _____ Occupation: _____ Left or Right Handed

Family Physician _____

How did you hear about us? M.D. _____ Friend/Name _____ Other _____

When did this problem begin? _____

If accident, place where occurred: Home Work Auto Other _____

Briefly describe what happened and/or what is bothering you: _____

On a scale from 0 (no pain) to 10 (severe pain) please rate your pain level: _____

What makes it better? _____

What makes it worse? _____

Have you been treated previously for this condition? Yes No

Where? _____ When? _____

Where? _____ When? _____

List all medication you are taking including "over the counter" and herbals: _____

List all operations in the past: _____

Check appropriate history of past/present conditions:

Heart	YES	NO	Tuberculosis	YES	NO
High Blood Pressure	YES	NO	Hepatitis/Liver	YES	NO
Circulation	YES	NO	Kidney or Bladder	YES	NO
Phlebitis/Blood Clots	YES	NO	Mental or Emotional	YES	NO
Asthma/Emphysema/Lung	YES	NO	Lyme Disease	YES	NO
Diabetes	YES	NO	Arthritis	YES	NO
Thyroid	YES	NO	Cancer	YES	NO
Epilepsy/Seizure/Convulsions	YES	NO	Ulcer or Gastro-Intestinal	YES	NO
Stroke	YES	NO	Allergies	YES	NO
Neck/Back	YES	NO	Other _____		
Pregnancy (current)	YES	NO			

What goals would you like to achieve through physical therapy? _____

If applicable: Do you want a Social Services consult? _____