

*Under Medicare and the Maryland practice act we are required to obtain a complete medical history on all patients.
This information is protected under HIPAA laws. Please answer all questions to the best of your ability.*

Last Name: _____ **First Name:** _____ **MI:** _____ **Date:** ___/___/___
DOB: ___/___/___ **Age:** _____ **Sex:** M / F **Hand Dominance:** R / L **Height:** _____ **Weight:** _____
 How did you hear about us? _____
 Family Doctor: _____ Referring Doctor: _____

If accident, circle place where occurred: **Home** **Auto** **Work** **Sports** **Other** **Next Doctor's Visit:** ___/___/___
Occupation: _____ **Current work status:** _____ **Do you have any lifting restrictions?** Y / N
 Do you live alone? Y / N **Are there stairs where you live?** Y / N

What is the reason for your visit today? _____

Briefly describe how your problem began: _____

What goals would you like to achieve through therapy? _____

Date of onset/injury: ___/___/___ **Date of surgery:** ___/___/___ **Type of Surgery:** _____

Treatments for your current chief complaint have included: (Circle all that apply) No Treatment Received Yet

Physical Therapy	Chiropractic Care	Pain management	Mechanical Traction
Massage	Injections	Aquatic Therapy	Brace/Tape
Surgical Intervention	Personal Training	Athletic Training	Other: _____

Have any diagnostic tests have been performed for this problem? (circle all that apply)
 X-rays Bone Scan Doppler Ultrasound MRI EMG CT Scan Bloodwork Other: _____

Please list body part tested and date tested: _____

Have you had similar symptoms in the past? Y / N **Have you received Home Health PT prior to coming here?** Y / N

Please circle where you hurt: **Where did your pain start?** _____



Since it started, pain is: getting worse improving the same
 Describe pain: sharp dull aching sore throbbing cramping
 burning shooting stabbing squeezing constant intermittent
 other: _____

What makes it worse? _____

What makes it better? _____

Does time of day affect pain? _____

Does pain wake you from sleep? _____

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine):
 Least: 0 1 2 3 4 5 6 7 8 9 10 **Worst:** 0 1 2 3 4 5 6 7 8 9 10 **Present:** 0 1 2 3 4 5 6 7 8 9 10

Do you have any tingling, numbness or loss of skin sensation? Y / N If so, where? _____

What increases this? _____ What decreases this? _____

Do you have any weakness? Y / N, where? _____ How long has it been present? _____

Do you have any swelling? Y / N, where? _____ How is it being managed? _____

Have you had any recent falls? Y / N **Do you use any of the following:** Cane Walker Crutches Wheelchair

How would you rate your current health? excellent very good good fair poor

Please circle yes or no if you have or have had any of the following conditions:

<u>Yes / No</u>		<u>Yes / No</u>		<u>Yes / No</u>	
Smoke/Chew Tobacco	Y / N	Diabetes	Y / N	Sexually Transmitted Disease	Y / N
packs per day: _____		Heart Attack	Y / N	Osteoarthritis	Y / N
Use of Illegal Substances	Y / N	Cardiac Bypass	Y / N	Rheumatoid Arthritis	Y / N
Drink Alcoholic Beverages	Y / N	Cardiac Stents	Y / N	Osteoporosis or Osteopenia	Y / N
amount per day: _____		Angina/Chest Pain	Y / N	Scoliosis	Y / N
High Blood Pressure	Y / N	Hepatitis	Y / N	Headaches or Migraines	Y / N
High Cholesterol	Y / N	Emphysema	Y / N	Dizziness or Fainting	Y / N
Bowel/Bladder Dysfunction	Y / N	COPD	Y / N	Cancer (site: _____)	Y / N
Acid Reflux or Ulcers	Y / N	Asthma	Y / N	Recent Infection	Y / N
Thyroid Disorder	Y / N	Kidney Disease	Y / N	Recent Anticoagulant Medicine Use	Y / N
Bleeding Disorder	Y / N	Stroke	Y / N	Recent Antibacterial Medicine Use	Y / N
Seizures/Epilepsy	Y / N	Depression	Y / N	Consistent Steroidal Medicine Use	Y / N
Lyme Disease	Y / N	Lupus	Y / N	Multiple Sclerosis	Y / N
Pregnant (# wks _____)	Y / N	Fibromyalgia	Y / N	Congestive Heart Failure	Y / N

Please circle yes or no if in the past 3 months have you experienced:

	<u>Yes / No</u>		<u>Yes / No</u>
Persistent pain at night	Y / N	Change in or problems with bladder/bowel function	Y / N
Fevers, chills or night sweats	Y / N	Changes in hearing	Y / N
Unexplained weight loss	Y / N	Changes in mental abilities	Y / N
Unwarranted fatigue	Y / N	Frequent or severe headaches with no history of injury	Y / N
Unusual lumps or growths	Y / N	Problems with swallowing or changes in speech	Y / N
Pulsating pain anywhere in your body	Y / N	Changes in vision (blurriness or loss of sight)	Y / N
Constant and severe pain in leg or arm	Y / N	Problems with balance, coordination or falling	Y / N
Swelling without a history of injury	Y / N	Fainting spells/blackouts	Y / N
Shortness of breath	Y / N	Sudden unexplained weakness	Y / N
Frequent or severe abdominal pain	Y / N	Pain, tingling or numbness in and around your face	Y / N
Frequent nausea or vomiting	Y / N	Tingling or numbness in both of your arms or both legs	Y / N
Ringing in ears	Y / N	New moles or skin lesions	Y / N

Please Circle any that you may have/wear: Glasses Contacts Dentures Pacemaker Metal Implant Hearing Aides

List all previous surgeries and dates: _____

List all medications/supplements you are taking: _____

List all allergies that you may have: _____

To the best of my ability, I have given and included all pertinent medical information.

Patient/guardian signature: _____ Date: ____/____/____

Medical history reviewed by physical/occupational therapist and used in determining the plan of care.

Therapist signature: _____ Date: ____/____/____