



PATIENT MEDICAL HISTORY

**GENERAL INFORMATION**

Name:	Referring Physician:
Diagnosis:	When did symptoms begin:
Briefly describe symptoms:	
Cause of injury: Motor Vehicle Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No Employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of accident:
Describe nature of injury and treatment received:	
Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not, what was the last date you worked?
Job position:	Job Position involves: Sitting <input type="checkbox"/> Standing <input type="checkbox"/> Alternate Sit/Stand <input type="checkbox"/> Phone/Computer work <input type="checkbox"/> Headset <input type="checkbox"/>

**SURGERY** (Have you had any non-orthopedic surgery within the last 5 years?)

DATE	TYPE OF SURGERY

**PAST TRAUMA** (List car accident, falls, fractures, sprains, or strains)

DATE	TYPE OF TRAUMA	TREATMENT RECEIVED

Have you had any of the following medical or rehabilitative services (within the last 5 years)?

Service	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	Results of treatment or test		
Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Chiropractic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Emergency Room Care	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Injections	<input type="checkbox"/> Yes <input type="checkbox"/> No		Type:	Site:	Results:
CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No				
MRI	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Neurologist	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Orthopedist	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Additional Information					

List current medications: \_\_\_\_\_  
 \_\_\_\_\_



## PATIENT MEDICAL HISTORY

GENERAL MEDICAL HISTORY (Do you have or have you had any of the following?)			
<input type="checkbox"/>	Asthma, Bronchitis, Emphysema	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Shortness of Breath/Chest Pain	<input type="checkbox"/>	Cancer or Chemotherapy/Radiation
<input type="checkbox"/>	Heart Disease/Angina	<input type="checkbox"/>	Vision Problems
<input type="checkbox"/>	Do you have a Pacemaker?	Type:	<input type="checkbox"/>
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Hearing Problems
<input type="checkbox"/>	Heart Attack	Type:	<input type="checkbox"/>
<input type="checkbox"/>	Stroke/TIA	<input type="checkbox"/>	Severe Headaches
<input type="checkbox"/>	Blood clot	<input type="checkbox"/>	Dizziness or Faintness
<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	Emotional/Psychological Problems
<input type="checkbox"/>		<input type="checkbox"/>	Infectious Diseases
<input type="checkbox"/>		<input type="checkbox"/>	Hernia
<input type="checkbox"/>		<input type="checkbox"/>	Varicose Veins
<input type="checkbox"/>		<input type="checkbox"/>	Diabetes
<input type="checkbox"/>		<input type="checkbox"/>	Weight Loss/Energy Loss
<input type="checkbox"/>		<input type="checkbox"/>	Bowel or Bladder Problems
<input type="checkbox"/>		<input type="checkbox"/>	Sleeping Problems
<input type="checkbox"/>		<input type="checkbox"/>	Do you smoke?
<input type="checkbox"/>		<input type="checkbox"/>	Allergies
Please explain any of the above:			
List any family history concerns:			

### MUSCULAR/SKELETAL HISTORY

	Condition/injury/surgery	Description of surgery/injury		
<input type="checkbox"/>	Joint Replacement	Body Part:		
<input type="checkbox"/>	Neck Injury/Surgery	Type:	Level:	Date:
<input type="checkbox"/>	Shoulder Injury/Surgery	Type:	Level:	Date:
<input type="checkbox"/>	Elbow/Hand Injury/Surgery	Type:	Level:	Date:
<input type="checkbox"/>	Back Injury/Surgery	Type:	Level:	Date:
<input type="checkbox"/>	Knee Injury/Surgery	Type:	Level:	Date:
<input type="checkbox"/>	Leg/Ankle Injury/surgery	Type:	Level:	Date:
<input type="checkbox"/>	Any pins/medical implants	Explain:		
<input type="checkbox"/>	Numbness/Tingling	Where:		
<input type="checkbox"/>	Arthritis/Swollen Joints	What joints:		
<input type="checkbox"/>	Weakness	How does it manifest itself?		
<input type="checkbox"/>	Osteoporosis	Medication?		

### CURRENT HISTORY

Briefly describe your pain and how it is affecting your daily life: \_\_\_\_\_

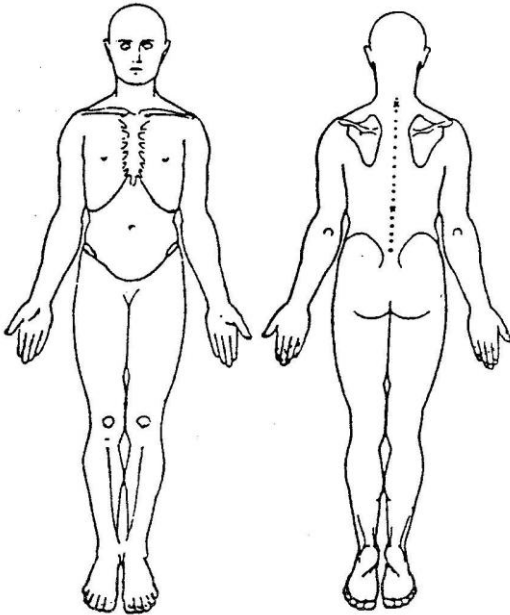
Which of the following positions or activities **increases** your pain/symptoms?

Position/Activity	Describe Pain	Position/Activity	Describe Pain
Lying on your back		Walking	
Lying on your side		Bending	
Lying on your stomach		Lifting/Carrying	
Sitting/Standing		Household chores	
Rolling in bed		Self care activities	
Getting in/out of car		Sexual Activities	
Stairs		Other	

Which of the following positions or activities **decreases** your pain/symptoms?

<input type="checkbox"/>	Lying on your back	<input type="checkbox"/>	Walking
<input type="checkbox"/>	Lying on your side	<input type="checkbox"/>	Use of hot pack or ice pack
<input type="checkbox"/>	Lying on your stomach	<input type="checkbox"/>	Massage
<input type="checkbox"/>	Sitting/Standing	<input type="checkbox"/>	Medication
<input type="checkbox"/>	Exercise	What type?:	How often?:

On the drawing below, **draw** the location of your pain by shading in the area involved.



**Circle** your pain level - (0=pain free & 10=severe-go to emergency room type pain)

0 1 2 3 4 5 6 7 8 9 10

Describe your pain, stiffness, or sensory changes:

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**ADDITIONAL INFORMATION**

How long can you sit/stand without pain?  < 15 minutes;  15-30 minutes;  > 30 minutes

Do your symptoms wake you at night?  Yes  No      How many hours do you sleep uninterrupted? \_\_\_\_\_

Do you exercise on a regular basis?  Yes  No

Are you pregnant?  Yes  No      Estimated Due Date: \_\_\_\_\_

Is there anything in your life that you feel is limiting your healing process? \_\_\_\_\_

\_\_\_\_\_

List any other information that would assist us in your care: \_\_\_\_\_

\_\_\_\_\_

What goal do you want to achieve in PT? \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_