PATIENT MEDICAL HISTORY

GENERAL INFORMATION

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

SURGERY (Have you had any non-orthopedic surgery?)

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		Date	Results of treatment or test		
Physical Therapy	☐ Yes ☐ No				
Chiropractic Services	☐ Yes ☐ No				
Emergency Room Care	☐ Yes ☐ No				
Injections	☐ Yes ☐ No		Type:	Site:	Results:
CT Scan	☐ Yes ☐ No				
MRI	☐ Yes ☐ No				
Neurologist	☐ Yes ☐ No				
Orthopedist	☐ Yes ☐ No				
Additional Information					

List current medications: _____

_____

INTEGRATED PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

GENERAL MEDICAL HISTORY (Do you have or have you had any of the following?)

☐	Asthma, Bronchitis, Emphysema	☐	Anemia	☐	Infectious Diseases
☐	Shortness of Breath/Chest Pain	☐	Cancer or Chemotherapy/Radiation	☐	Hernia
☐	Heart Disease/Angina	☐	Vision Problems	☐	Varicose Veins
☐	Do you have a Pacemaker?		Type:	☐	Diabetes
☐	High Blood Pressure	☐	Hearing Problems	☐	Weight Loss/Energy Loss
☐	Heart Attack		Type:	☐	Bowel or Bladder Problems
☐	Stroke/TIA	☐	Severe Headaches	☐	Sleeping Problems
☐	Blood clot	☐	Dizziness or Faintness	☐	Do you smoke?
☐	Epilepsy/Seizures	☐	Emotional/Psychological Problems	☐	Allergies

Please explain any of the above:

List any family history concerns:

MUSCULAR/SKELETAL HISTORY

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

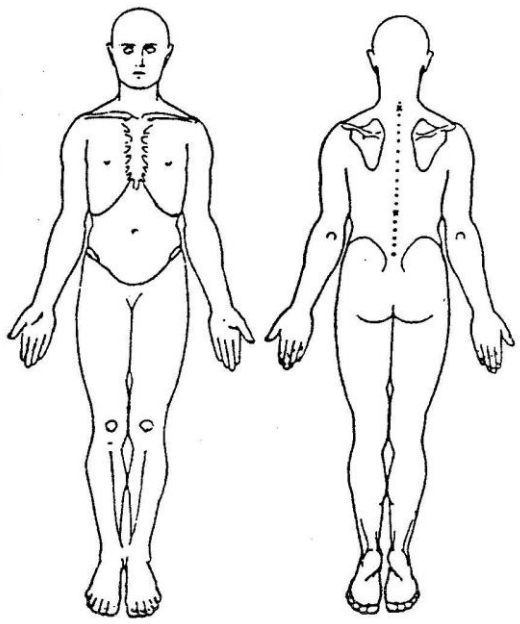
Which of the following positions or activities **decreases** your pain/symptoms?

INTEGRATED PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

☐	Lying on your back		☐	Walking	
☐	Lying on your side		☐	Use of hot pack or ice pack	
☐	Lying on your stomach		☐	Massage	
☐	Sitting/Standing		☐	Medication	
☐	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:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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: _____

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