

PATIENT MEDICAL HISTORY



Patient Name: _____

Onset date of illness/injury: _____ Primary Care Physician: _____

Referring Physician: _____ Follow-up Visit Scheduled Date: _____

Have you had surgery for this condition? Yes No Number of surgeries: _____

Type of surgery: _____

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-inflammatory _____ List of Medications: _____

Muscle Relaxers _____

Pain Medication _____

Please check if you have had any of the following medical/rehabilitative services for this injury/condition:

- CT Scan
- EMG/NCV
- MRI
- Myelogram
- X-Ray
- Other Diagnostic Test: _____
- Chiropractor
- Emergency Room Care
- General Practitioner
- Massage Therapy
- Neurologist
- Occupation Medicine Doctor
- Occupational Therapy
- Orthopedist
- Physical Therapy
- Podiatrist
- Other: _____

Please check if you have a history of any of the following:

- Anemia
- Asthma/Bronchitis/Emphysema
- Blood Clot/Emboli
- Cancer or Chemo/Radiation
- Diabetes
- Emotional/Psychological Problems
- Epilepsy/Seizures
- Heart Attack or Heart Surgery
- Heart Disease or Angina
- High Blood Pressure
- Infectious Disease
- Pacemaker
- Shortness of breath/chest pain
- Sleeping Problems/Disorders
- Stroke/TIA
- Thyroid Trouble/Goiter
- Tuberculosis
- Allergies
- Bowel or Bladder Problems
- Dizziness or Fainting
- Hernia
- Numbness or Tingling
- Severe or Frequent Headaches
- Varicose Veins
- Vision or Hearing Difficulties
- Weakness
- Weight Loss/Energy Loss
- Any Pins or Metal Implants
- Arthritis/Swollen Joints/Gout
- Back Injury/Surgery
- Elbow/Hand Injury/Surgery
- Joint Replacement
- Knee Injury/Surgery
- Leg/Ankle/Foot Injury/Surgery
- Neck Injury/Surgery
- Osteoporosis
- Shoulder Injury/Surgery

Are you pregnant? Y N

Is there any other information that you feel would assist us in your care? _____

Are you aware of what your diagnosis is? Yes No

What are your goals while in this program? _____

Patient/Guardian Signature: _____ **Date:** _____

I have reviewed this medical history with the patient: _____

Therapist Signature