

MEDICAL HISTORY FORM

PLEASE COMPLETE THE FOLLOWING. IF YOU DO NOT UNDERSTAND A QUESTION, PLEASE ASK YOUR THERAPIST FOR ASSISTANCE. THOSE CONSIDERED HIGH RISK MUST HAVE PHYSICIAN CLEARANCE FOR PARTICIPATION IN PHYSICAL THERAPY. THANK YOU.

NAME _____ Today's Date _____

Age _____ Height _____ Weight _____ Gender: M F

Do you have a pacemaker? Yes No Are you pregnant? Yes No

Occupation _____ Presently Working: Full Time ___ Part Time ___ Not Employed ___

Physical Activities at Work: _____

General Health: Excellent ___ Good ___ Average ___ Fair ___ Poor ___

Date of Last Physical Exam _____

Exercise Level: None ___ 1-2x's/wk ___ 3-4x's/wk ___ 5+x's/wk ___

Consisting of: _____

Do you experience any symptoms during heavy exercise: Y N

If yes, please explain _____

Stress Level: Low ___ Medium ___ High ___

Hobbies: _____

Are you currently seeing any of the following?

Medical Doctor	Yes No	Psychiatrist/Psychologist	Yes No	Chiropractor	Yes No
Dentist	Yes No	Physical Therapist	Yes No	Other _____	Yes No

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical Condition, physical exam, etc.): _____

In the past 6 months, have you had:

Difficulty with bowel/bladder control	Yes No	Fever/Chills	Yes No	Numbness	Yes No
Numbness in the genital or anal area	Yes No	Night Pain/Sweats	Yes No	Weakness	Yes No
Vision/hearing problems	Yes No	Dizziness/fainting	Yes No	Bodily Discomfort	Yes No
Unexplained weight change	Yes No	Chest Pain	Yes No	Leg Swelling	Yes No
Shortness of Breath	Yes No	Other _____			

PLEASE SEE REVERSE SIDE

Have you ever been diagnosed as having any of the following?

Cancer	Yes No	If yes, what kind? _____			
Heart Problems	Yes No	Chemical Dependency/Alcoholism	Yes No	Depression	Yes No
High Blood Pressure	Yes No	Hepatitis	Yes No	Stroke	Yes No
Asthma	Yes No	Tuberculosis	Yes No	Anemia	Yes No

Emphysema/Bronchitis	Yes No	Rheumatoid Arthritis	Yes No	Kidney Disease	Yes No
Thyroid Problems	Yes No	Other Arthritic Conditions	Yes No	Allergies	Yes No
Diabetes	Yes No	Epilepsy/Seizures	Yes No	Multiple Sclerosis	Yes N
HIV/Acquired Immune Deficiency Syndrome	Yes No			Other	_____

Do you have any of the following risk factors for Heart Disease?

High Blood Pressure	Yes No	Diabetes	Yes No
High Cholesterol	Yes No	Smoking	Yes No
Heart Disease	Yes No	Family history of heart disease	Yes No

Please list any surgeries or conditions for which you have been hospitalized which may pertain to your current condition. Include the reason for the surgery/hospitalization and approximate date.

<u>DATE</u>	<u>SURGERY/HOSPITALIZATION</u>
_____	_____
_____	_____
_____	_____
_____	_____

What Prescription Medications are you currently taking and at what quantity (including pills, injections, and skin patches)?

Amount of Alcohol Consumption (# of Drinks) per Week _____

Number of Cigarettes/Cigars per Week _____

Does any injury or condition significantly impact your function in these areas?

Work	Yes No	Mobility at Home	Yes No	Food/Meals	Yes No
Personal Care	Yes No	Safety	Yes No	Transportation	Yes No
Finances	Yes No	Emotional stability, including withdrawal or depression	Yes No		

Do you have adequate support at home – physical and emotional – to meet the challenges of your condition? Yes No

For Office Use Only

Form reviewed with patient? Yes ___ No ___ _____
 Therapist Signature Date