Patient Medical History

Patient Name _____ Date _____

Referring Physician _____ Family Physician _____

Age _____ Height _____ Weight _____

Have you ever been diagnosed with any of the following: (Check YES or NO for each items)

MEDICAL CONDITIONS	YES	NO	DATE OF ONSET/COMMENTS
Allergies (type)			
Anemia			
Arthritis (type and location)			
Back Injury/Surgery			
Blood Clot			
Bowel Control/Bladder Leakage/Urgency			
Broken Bones (list)			
Cancer or Chemotherapy/Radiation			
Chest Pain/Angina			
Coronary Heart Disease			
Diabetes (type)			
Difficulty Sleeping			
Dizziness/Vertigo			
Elbow/Hand Injury or Surgery			
Fainting			
Fibromyalgia			
Fractures (list)			
Headaches (how often)			
Heartburn			
Heart Attack/Surgery			
Hernia			
High Blood Pressure			
Hip Injury/Surgery			
History of Falling			
Increased Pain at Night			
Infectious Disease (Hepatitis/HIV)			
Joint Replacement (location)			
Kidney/Urinary Tract Disease			
Knee Injury/Surgery			
Leg Injury/Surgery			
Lung Disease			

Nausea/Vomiting			
Neck Injury/Surgery			
Numbness/Tingling (location)			
Osteoarthritis (location)			
Osteoporosis			
Pacemaker			
Pins/Metal Implants (location)			
Pregnant (trimester)			
Recent Procedures/Injections			
Respiratory Problems			
Restrictions with Walking/Exercising			
Seizures (type)			
Shoulder Injury/Surgery			
Shortness of Breath			
Skin Conditions (type/location)			
Smoke			
Stroke/TIA			
Tumors			
Vision or Hearing Problems			
Weakness			
Weight Loss			

Most insurance plans have a maximum benefit for outpatient physical therapy services that may be combined with other therapy services. We will help you monitor your visits, but we will need to be made aware of any previous treatment you may have had. Please check if you have received any of the following services this year:
_____ Chiropractor _____ Physical Therapy _____ Occupational Therapy _____ Speech Therapy

Please list any surgeries or other conditions for which you have been hospitalized, include the approximate date and the reason for the surgery or hospitalization.

Date Surgery / Hospitalization Reason

_____

_____

_____

_____

Do you smoke tobacco? Yes ☐ No ☐ If yes, how much per day? _____

What are your goals for physical therapy? _____

_____