Patient Medical History Form

NAME: ____ **AGE** ________

(First) (Middle) (Last)

Next appt. with referring Doctor ___/___/____ Height: _____ Weight: ____lbs. ☐RT Handed ☐LT Handed

PAST MEDICAL HISTORY (CHECK ALL THAT APPLY)

☐AIDS/HIV ☐Hepatitis ☐Open Wound ☐Anemia ☐Swelling of hands / feet ☐ Diabetes
☐Cancer ☐Herpes ☐Osteoporosis ☐Chest Pain ☐Dizziness/fainting/lightheaded ☐Lyme Disease
☐Stroke ☐Pacemaker ☐Aortic Aneurysm ☐Infection ☐Breathing Problems ☐Heart Disease
☐Polio ☐Arthritis ☐Seizures ☐Depression ☐Bowel/Bladder Trouble ☐Fibromyalgia
☐Asthma ☐Emphysema ☐Kidney Problems ☐Blood Disorder ☐Metal or Other Implants
☐High Blood Pressure ☐My-fascial Pain Syndrome ☐Other________________________

MEDICATIONS: (prescription, over the counter, & supplements): ________________________________

ALLERGIES: ☐Bees ☐Strawberries ☐Shellfish ☐Lotions ☐Latex ☐Rubber ☐Tape ☐Cortisone☐Other____________

ARE YOU PREGNANT?☐YES ☐NO WEIGHT GAIN/LOSS IN 12 MONTHS? (+-)_____lbs. TOBACCO USE: ☐YES ☐NO ALCOHOL: ☐YES ☐NO

LIST ANY SURGERIES, SERIOUS INJURIES, FRACTURES, STRAINS, DISLOCATIONS:	DATE

CURRENT INJURY/REASON FOR ATTENDING P.T.:________________________ **DATE OF ONSET:** ___/___/____

HOW DID CURRENT INJURY OCCUR? ____

WORKPLACE/MVA/SLIP & FALL: ☐YES ☐NO **DID YOU HAVE:** ☐X-RAY ☐MRI ☐CAT SCAN ☐OTHER ____________

ANY RECENT SURGERIES? ☐YES ☐NO **DATE OF SURGERY:** ___/___/____ **PROCEDURE DONE:** ____________

HAVE YOU HAD PHYSICAL THERAPY IN THE PAST YEAR FOR THIS INJURY ☐YES ☐NO **DATE OF LAST VISIT:** ___/___/____

DOES YOU CONDITION INTERFERE WITH: ☐ HOUSE/YARD WORK ☐ JOB/WORKING ☐ SLEEPING ☐ STANDING
☐ WALKING ☐ GETTING IN & OUT OF THE TUB ☐ SITTING ☐ HEAD MOVEMENTS
☐WALKING UP AND DOWN THE STAIRS ☐REACHING TO THE SIDE OR OVERHEAD ☐ OTHER: ____________

CURRENT PAIN LEVEL: (None)0 1 2 3 4 5 6 7 8 9 10(high) **PAIN WITH COUGHING/SNEEZING?** ☐YES ☐NO

RATE YOUR DAILY ACTIVITY: 0 1 2 3 4 5 6 7 8 9 10

RATE YOUR BALANCE: (Poor)0 1 2 3 4 5 6 7 8 9 10(good)

PAIN IS (CHECK ALL THAT APPLY): ☐ SHARP ☐ DULL ☐ INTERMITTENT ☐ CONSTANT ☐ DEEP ☐ SHOOTING ☐ THROBBING
☐ PINCHING ☐ TIGHT ☐ BURNING ☐ DIFFUSE

CONDITION BEGAN: ☐ SUDDENLY ☐ GRADUALLY ☐ TRAUMA ☐ CHRONIC **CONDITION IS:** ☐ BETTER ☐ WORSE ☐ SAME

WHAT INCREASES PAIN? ____

WHAT DECREASES PAIN?____

DO YOU PARTICIPATE IN SPORTS, EXERCISE OR GYM ACTIVITIES REGULARY:☐YES ☐NO **COMMENTS**____________

DOES YOUR: ☐Knee give way ☐Knee lock up ☐Knee cap shift **HAVE YOU HAD A SIGNIFICANT FALL IN THE LAST YEAR?** ☐ YES ☐NO

ARE YOU AWARE OF YOUR DIAGNOSIS/PROGNOSIS? ☐YES ☐NO **CONCERNS:**____________________

ARE THERE ANY PERSONAL CIRCUMSTANCES THAT MAY AFFECT YOUR TREATMENT?____________________

WHAT DO YOU HOPE TO ACCOMPLISH OR GAIN FROM YOUR PHYSICAL THERAPY? ____________________

Consent to Treatment: To the best of my knowledge, information provided herein is correct. I understand that I have been referred for rehabilitative treatment & care to Peak Physical Therapy. I understand my diagnosis and treatment plan will be discussed during my first appointment and I have the right to question and/or refuse any treatment prior to it being applied. By signing this agreement, I consent to have this facility provide treatment as prescribed by my physician and/or advised by my therapist.

SIGNATURE____ DATE______________