MEDICAL HISTORY FORM

PLEASE COMPLETE THE FOLLOWING. IF YOU DO NOT UNDERSTAND A QUESTION, PLEASE ASK YOUR THERPAPIST 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 Late 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.

DATE SURGERY/HOSPITALIZATION

______ ____
______ ____
______ ____
______ ____

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

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For Office Use Only
Form reviewed with patient? Yes ___ No ___ ____
Therapist Signature Date