Medical History Form

Patient Name: _____ Account Number: _____

Height: _____ft _____in Weight:_____(pounds) Date of injury:_____

Diagnosis as stated to you by your physician: _____

How did this injury/ exacerbation occur? _____

Have you been hospitalized for the present condition? □ Yes □ No If Yes, date: _____

Have you had surgery for the present condition? □ Yes □ No If Yes, date: _____

If yes, surgery type:_____

Have you had any falls this past year? □Yes □No If Yes, how many?_____

Have you received previous treatment for this condition? □ Yes □ No If Yes, date: _____

If yes, please summarize:_____

Have you ever had any of the following? □ EMG □ CT SCAN □ MYELOGRAM □ MRI □ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Acquired Respiratory Distress Syndrome	□ Yes	□No
Angina	□ Yes	□No
Anxiety or Panic Disorders	□ Yes	□No
Arthritis (RA, OA)	□ Yes	□No
Asthma	□ Yes	□No
Chronic Obstructive Pulmonary Disease (COPD)	□ Yes	□No
Congestive Heart Failure (CHF)	□ Yes	□No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	□ Yes	□No
Depression	□ Yes	□No
Diabetes	□ Yes	□No
Emphysema	□ Yes	□No
Hearing Impairment	□ Yes	□No
Heart Attack	□ Yes	□No
Multiple Sclerosis	□ Yes	□No
Osteoporosis	□ Yes	□No
Parkinson's Disease	□ Yes	□No
Peripheral Vascular disease	□ Yes	□No
Stroke or TIA	□ Yes	□No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	□ Yes	□No
Visual Impairment (cataracts, glaucoma, macular degeneration)	□ Yes	□No

Allergies	□ Yes	□No
Headaches	□ Yes	□No
Back Injury	□ Yes	□No
Bleeding Disorders	□ Yes	□No
Bowel / Bladder Abnormalities	□ Yes	□No
Cancer	□ Yes	□No
Dizzy or Fainting Spells	□ Yes	□No
Epilepsy or Seizure Disorder	□ Yes	□No
Fracture	□ Yes	□No
Hepatitis A, B, C	□ Yes	□No
Hernia	□ Yes	□No
High Blood Pressure	□ Yes	□No
HIV/AIDS	□ Yes	□No
Hypoglycemia	□ Yes	□No
Immunosuppressant Condition or Medication	□ Yes	□No
Kidney Problems	□ Yes	□No
Liver / Gallbladder Problems	□ Yes	□No
Metal Implants	□ Yes	□No
Nausea / Vomiting	□ Yes	□No
Pacemaker	□ Yes	□No
Defibrillator	□ Yes	□No
Pregnancy	□ Yes	□No
Ringing in Your Ears	□ Yes	□No
Sexual Dysfunction	□ Yes	□No
Skin Abnormalities	□ Yes	□No
Smoking	□ Yes	□No
Special Diet Guidelines	□ Yes	□No
Tuberculosis	□ Yes	□No

Please continue to 2nd page

Precision
Physical Therapy and Wellness

Medical History Form (page 2)

Patient Name: _____ Account Number: _____

Are you on any medications? Click here if attached: □ Attached Please list (you may use reverse side):

_____

_____

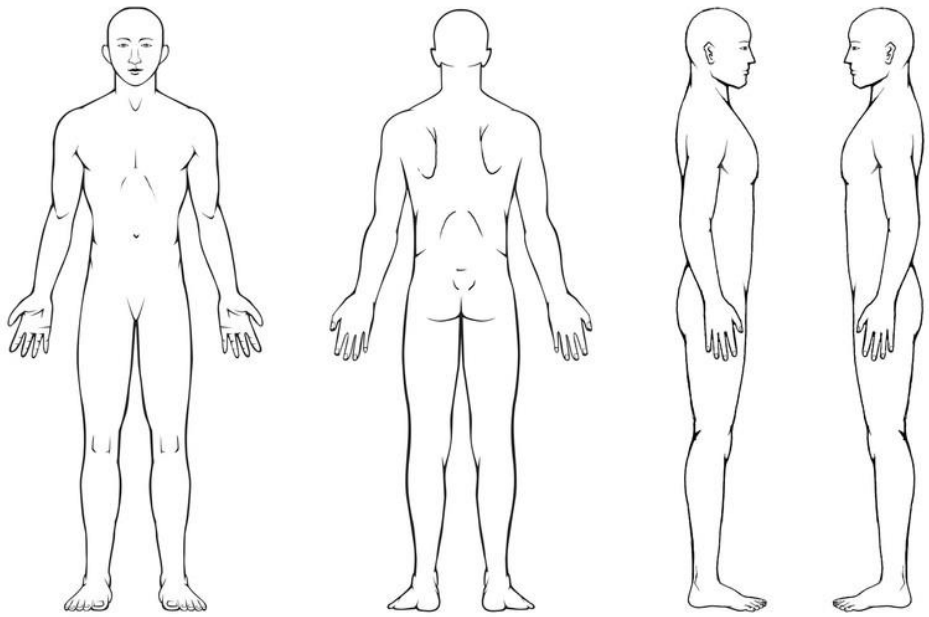
To help us understand your symptoms, please circle all that apply.

My pain is worse: in the morning/ during the day/ at night/ constant/ with activity/ during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worst_____

Pain Diagram

Using the key provided, please indicate the symbol(s) representing your pain over the area of the body as it relates to your present condition



Key

UUU (for Up↑) or DDD (for Down↓) Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Is there any other information regarding your medical history that we should know about? _____

_____

What is your goal for therapy at this time?

_____

_____

Signature of Patient or Guardian (if patient is a minor): _____ Date: _____