

Medical History Form

Name (print): _____ Address: _____
 Phone: (Home) _____ (Cell/Work) _____ SSN: _____ D.O.B. ____/____/____ Age: _____
 Family Physician: _____ Marital Status: _____
 Alternate Contact Name: _____ Phone: _____ Relationship to Patient: _____
 Occupation: _____ Employer: _____ Currently working? Yes / No
 If Yes-Full Time / Part time Describe your occupation and physical demands: _____

To help the therapist better assess the cause of your problem; please answer the questions as completely as possible.

1. When did the symptoms start? _____
2. What tests or treatment have you had for this problem? _____

3. In the past 30 days, have you had any of the following: Hospital admission Therapy Nursing home admission Home health care. If yes, when? _____
4. Are you experiencing pain? Yes No
 If yes, please rate the pain on the scale below from 0-10:
** 0 = No pain; 10 = Need to go to the emergency room!*

Minimal			Moderate					Severe		
0	1	2	3	4	5	6	7	8	9	10

- What makes your symptoms worse? _____
 What makes your symptoms better? _____
5. Have your symptoms changed since they first began? Yes No
 Describe: _____
 6. What activities does this problem interfere with? (i.e. walking, driving, dressing, cooking, etc.)

 7. What personal goals would you like to reach by the end of therapy? _____

 8. Please list all previous surgeries: _____
 9. Please list all known allergies: _____
 10. List all medications you are CURRENTLY using: (or attach a copy)

11. Medical illnesses/information: (Please check Yes or No)
- | | |
|---|--|
| Heart: <input type="checkbox"/> Yes <input type="checkbox"/> No
Lung: <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia: <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidney: <input type="checkbox"/> Yes <input type="checkbox"/> No
Seizures: <input type="checkbox"/> Yes <input type="checkbox"/> No
Stroke: <input type="checkbox"/> Yes <input type="checkbox"/> No
Neuropathy: <input type="checkbox"/> Yes <input type="checkbox"/> No
DVT: <input type="checkbox"/> Yes <input type="checkbox"/> No
Hand Dominance: LEFT / RIGHT | Diabetes: <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer: <input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pressure: <input type="checkbox"/> Yes <input type="checkbox"/> No
Bowel/Bladder: <input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach: <input type="checkbox"/> Yes <input type="checkbox"/> No
Smoker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Defibrillator: <input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker: <input type="checkbox"/> Yes <input type="checkbox"/> No
Metal Implants: <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|
- If you checked **YES** to any of the above, please explain: _____

12. How do you rate your current health? Excellent Very good Fair Poor
13. Females only: Are you pregnant? Yes No

Patient signature: _____ **Date:** ____/____/____
Therapist signature: _____ **Date:** ____/____/____



Patient name: _____
 MR#: _____
 ACCT#: _____
 Dr.: _____