

PATIENT MEDICAL HISTORY



Name: _____ Referring Physician: _____

Family Physician: _____ Is an attorney involved in this case? Yes No

Was this injury caused by an accident? Yes No If so, what date did this injury occur? _____

Have you had surgery for this injury? Yes No If so, what date was your surgery? _____

Which of the following OVER THE COUNTER medications have you taken in the past week? Prescription Medication taken in the past week?

Aspirin YES NO
Tylenol YES NO
Advil/Ibuprofen YES NO
Alleve YES NO
Antacids YES NO
Decongestants YES NO
Antihistamines YES NO

Pain Medication YES NO
Muscle Relaxers YES NO
Anti-inflammatories YES NO
Please list medication if known:

Please check any of the following Medical Professionals or services for this injury / episode.

____ Chiropractor
____ General Practitioner
____ Neurologist
____ Orthopedist
____ Podiatrist
____ Emergency Room Care

____ CT Scan
____ MRI
____ X-rays
____ Physical Therapy
____ Occupational Therapy

In the past 3 months have you seen a physician for an illness or injury not related to the current episode of symptoms?
YES NO

Do you have or have you ever had any of the following?

____ Asthma/ Bronchitis/ Emphysema
____ Shortness of Breath/ Chest Pain/ Angina
____ Coronary Heart Disease/ Pacemaker
____ Heart Attack/ Surgery
____ High Blood Pressure
____ Stroke/ TIA
____ Blood Clot/ Emboli
____ Gout
____ Epilepsy/ Seizures
____ Thyroid Trouble/ Goiter
____ Osteoporosis
____ Infectious Diseases
____ Diabetes
____ Cancer/ Chemotherapy/ Radiation
____ High Cholesterol
____ Recent weight loss/gain
____ Increased fatigue in last 30 days

____ Severe or frequent Headaches
____ Vision or Hearing Difficulties
____ Numbness or Tingling
____ Dizziness or Fainting
____ Weakness
____ Osteoarthritis or Rheumatoid Arthritis
____ Hernia
____ Varicose Veins
____ Allergies: _____
____ Any Pins or Metal Implants
____ Joint Replacement
____ Currently Pregnant
____ Depression or Chemical Dependency
____ Bowel/ Bladder Problems
____ Family history of heart disease
____ Recent onset of fever/chills/sweats

Do you currently smoke? YES NO
Do you currently exercise 3-5 times per week? YES NO
Are you aware of your Diagnosis? YES NO
Do you need to speak to a social worker concerning your rehabilitation? YES NO
Any other information/conditions that would assist in your care? _____

Pain Rating Today: 0 1 2 3 4 5 6 7 8 9 10
No Pain Strong Emergency Room

Patient/ Guardian Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____