

MEDICAL HISTORY FORM

PATIENT NAME: _____ Acct#: _____

Please check if you have been diagnosed with any of the following conditions:

- | | | | |
|--|----------------------------|---------------------------|-----------------------|
| _____ Diabetes(I/II) | _____ Heart Disease | _____ High Blood Pressure | _____ Cancer |
| _____ Pacemaker | _____ Stroke (TIA or CVA) | _____ Seizures | _____ Metal Implants |
| _____ Back Pain | _____ Circulation problems | _____ Osteoporosis | _____ Stomach ulcers |
| _____ Broken bones | _____ Respiratory Problems | _____ Depression | _____ Asthma |
| _____ Blood Clots | _____ Rheumatoid Arthritis | _____ Thyroid Problems | _____ Kidney problems |
| _____ Infectious Diseases (HIV, Hepatitis, TB, etc.) _____ | | | |
| Other: _____ | | | |

Surgical History: _____

Have you recently noted? Check all that apply:

- | | | | |
|---------------------------|----------------------------------|----------------------------------|---------------------------------------|
| _____ Nausea/Vomiting | _____ Dizziness spells | _____ Pain at night | _____ Currently pregnant |
| _____ Unusual weakness | _____ Visual problems | _____ Heart Palpitations | _____ Hearing problems |
| _____ Bleeding | _____ Difficulty walking | _____ Joint pain or swelling | _____ Fever /chills/sweats |
| _____ Chest Pain | _____ Shortness of breath | _____ Incontinence | _____ Productive/Chronic Cough |
| _____ Difficulty sleeping | _____ Loss of Appetite | _____ Unexplained weight changes | _____ Fatigue or myalgia |

Have you recently traveled from an area with widespread or ongoing community spread of coronavirus? Yes No

Have you had direct prolonged contact with someone with confirmed case of coronavirus? Yes No

How many times have you fallen in the past 12 months? _____ Did it results in an injury? Yes No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? Yes No

Please list all, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:

Sex: Male Female

Height: _____ **Weight:** _____

Are you: Right handed Left handed

Do you have any allergies? Yes No If yes, please list: _____

With whom do you live:

Alone Spouse only Spouse and others Child Other _____

Where do you live:

Private home Apartment/rented room Assisted living/group home Hospice Other _____

Does your home have:

Stairs, no railing Stairs, railing Ramps Uneven terrain

Please explain: _____

Employment/Work (Job/School/Play):

Working: Full time Part time Retired Unemployed Occupation: _____

PATIENT NAME: _____

General Health Status, Please rate your health; Excellent Good Fair Poor

Date of onset of current symptoms/injury: Month _____ Day _____ Year _____

Describe the problem(s) for which you seek therapy: _____

Explain how problem(s) occurred: _____

How are you taking care of the problem(s) now? _____

What makes the problem(s) **better**? _____

What makes the problem(s) **worse**? _____

What functions could you perform before, that now you are unable to do? _____

What are your goals for therapy? _____

Have you ever had the problem(s) before? _____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc. _____

Have you received X-rays, MRI, CT scan, Bone Scan, etc. for this problem? If so, what were the results _____

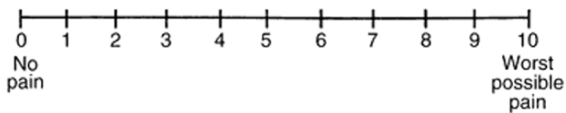
Are you aware of any physical reason why you should not receive treatment? Yes No

If yes, please tell us what it is: _____

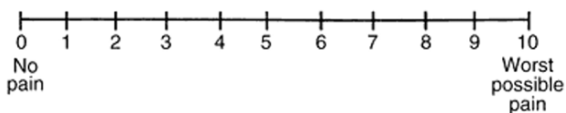
Pain Rating:

If you have pain, what is your pain level? Circle

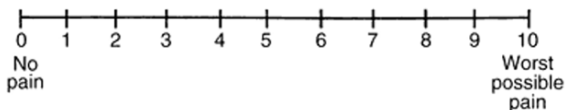
CURRENT Pain



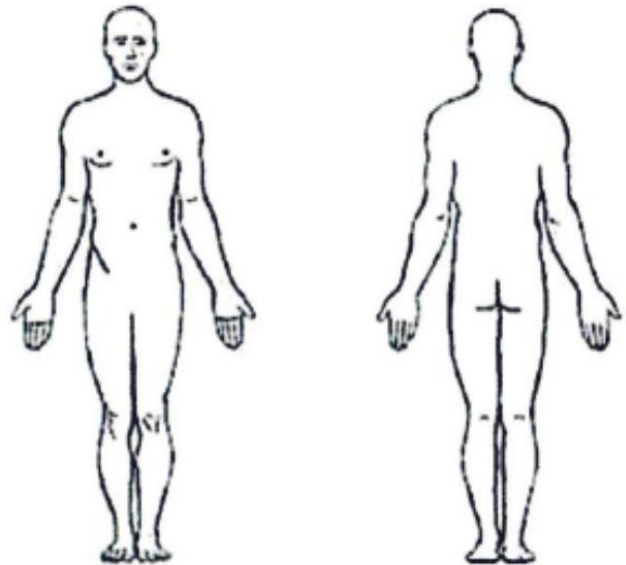
Pain level at **BEST**



Pain level at **WORST**



Please mark the location of pain with an "X"



To the best of my knowledge the above information is accurate and complete.

Signature: _____ Date: _____

Thank you for completing this questionnaire. It will allow us to better serve your needs.

Therapist signature: _____ Date: _____