

MEDICAL HISTORY FORM

PATIENT NAME: _____ Acct#: _____

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

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

Surgical History: _____

Have you recently noted? Check all that apply:

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

How many times have you fallen in the past 12 months? _____ **Did it results in an injury?** 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: _____

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

PATIENT NAME: _____

Physician Name: _____ Diagnosis: _____ Surgery performed and Date: _____

Explain how problem(s) occurred: _____ Date of Onset: _____

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 you are now 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. _____

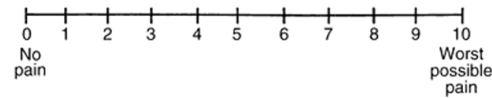
Have you received X-rays, MRI, CT scan, Bone Scan, etc. for this problem? If so, what were the results _____

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

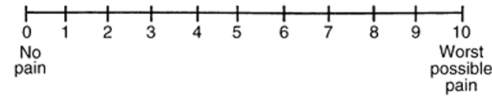
If yes, please tell us what it is: _____

Pain Rating:
If you have pain, what is your pain level? Circle

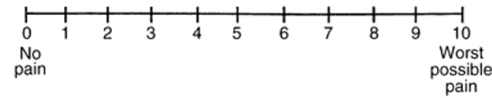
CURRENT Pain



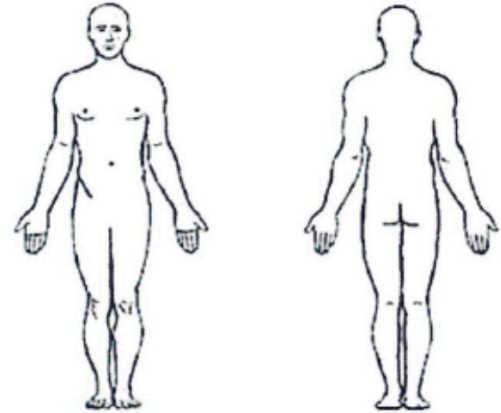
Pain level at **BEST**



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: _____

Therapist Comments: _____

