

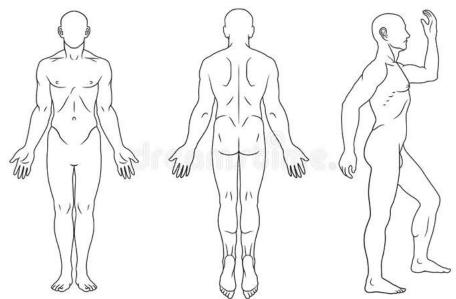
1st Choice is Your Best Choice!

Medical History Form

Client Name		Date							
Occupation	Date of next physician's visit								
Date of Injury/Surgery	Have you ever had these symptoms before? \square Yes \square No								
Check which apply to your cur	rent condition	:							
☐ Work related injury	□ Recurrence	ce of p	orevious injury	\square Injury related to falling					
☐ Motor vehicle accident	□ Injury rela	ted to	lifting	□ Other					
□ Cause unknown	□ Athletic/r								
Have you ever had a related s	urgery? 🗆 Yes	s 🗆 l	No						
Do you have, or have you had	, any of the fo	llowin	g:						
	<u>Yes</u>	<u>No</u>			<u>Yes</u>	<u>No</u>			
Diabetes			Allergies to Aspirin						
Chest Pain/Angina			Allergies to Heat						
High Blood Pressure			Allergies/Poor Tolera	nce to Cold					
Heart Disease			Other Allergies						
Heart Attack			Hernia						
Heart Palpitations			Seizures						
Pacemaker			Metal Implants						
Headaches			Dizziness/Fainting						
Kidney Problems			Recent Fractures						
Are you Pregnant?			Surgeries						
Cancer			Skin Abnormalities						
Osteoporosis			Nausea/Vomiting						
Bowel/Bladder Abnormalities			Ringing in your Ears						
Urine Leakage			Rheumatoid Arthritis						
Asthma/Breathing Difficulties			Stroke/CVA						
Liver/Gallbladder Problems			Hypoglycemia						
Smoking			Depression						
Other			Anxiety						
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If yes on any of the above, pleas	e brietly explain	n and (give approximate dates:						

ls there any other information regarding your past medical history that we should know about?
List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.
Do you participate in any sports, exercise programs or activities on a regular basis? \Box Yes \Box No
Do you smoke? 🗆 Yes 🗆 No
Emergency Contact Information: Name Telephone
Please describe the problem for which you are coming to physical therapy and the history of that problem:

Please indicate on the pictures below where your symptoms are located:



 \square Right Side \square Left Side \square Both

What was your level of function before your problem occurred (regular exercise, hobbies, activity level)?										
WI	hat are your go	oals for	physico	al therc	apy?					
Νι	umeric Pain Ra	ting Sco	ale - Ple	ease ci	rcle ap	propric	ate ans	wer		
1.	How would y	ou rate	your p	ain RIG	ON TH	W?				
	0 1 No Pain	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
2.	How would yo	ou rate	your US	SUAL le	vel of p	ain du	iring the	e last w	eek?	
	0 1 No Pain	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
3.	How would yo	ou rate	your BE	ST leve	el of pa	in durin	ng the I	ast wee	∋k?	
	0 1 No Pain	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
4.	How would yo	ou rate	your W	ORST I	evel of	pain dı	uring th	ne last v	veek?	
	0 1 No Pain	2	3	4	5	6	7	8	9	10 Worst Pain Imaginable
CI	ient's Signature)					 Dat	<u>—</u>		
Siç	gnature of Guo	ırdian if	Client	is a Mir	nor		Date	<u>—</u>		
	erapist Sianatu	ıre					 Dat			