

Medical History

Patient Name _____ DOB _____

Occupation: _____ Type of Work, ex. Lifting, sitting, standing etc. _____

Past Medical History- Do you have previous History of:

Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No
High Blood Pres.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Infectious DX.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No	Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	GI Symptoms	<input type="checkbox"/> Yes <input type="checkbox"/> No
Strokes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Trauma/Injury	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fractures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pulmonary DX.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney DX.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	Explain: _____		Other: _____	

Internal/external device or support: Yes No (Specify) _____

Are you Pregnant? Yes No

Explanation for any of the above: _____

Medication: Please list all currently taken. _____

Past Surgery: _____

Previous Medical Tests (ex. CAT Scan, EMG etc.) Yes No _____

Exercise/activity level: Min Mod. Max.

Type of Activities: Walking Jogging Running Exercise

Primary Doctor: _____

Orthopedic Doctor: _____

I am aware of Diagnosis/prognosis, I have been referred for Physical Therapy Treatment by my Physician? Yes No

When did Problem(s) Begin (date)? _____

Have you received treatment for this condition before? Yes No
(If yes) Type & Where: _____

OFFICE USE ONLY

Verification Signature: _____

Date: _____

Patient File Number: _____

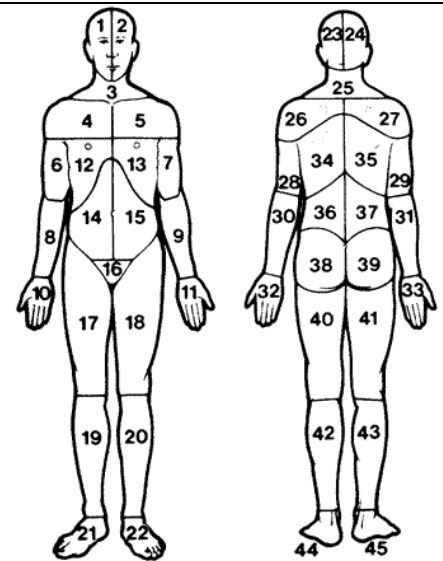


Fig. 1. Scoring template for pain drawing.

Indicate Pain, Burning, Numbness/Tingling, Cramping on the Diagram above.

Patient Signature X: _____

Date: _____