Medical History

Patient Name: _____ Date: _____

1. Have you ever been diagnosed or currently have the following conditions? (Please check)

☐ Heart Problems	☐ Tuberculosis	☐ Head / Neck Injury
☐ High Blood Pressure	☐ Diabetes	☐ Blood Disorder
☐ Rheumatoid Arthritis	☐ Stomach / GI Problems	☐ Osteoporosis
☐ Headaches	☐ Anxiety	☐ Dizzy / Fainting Spells
☐ Hepatitis	☐ Kidney Disease	☐ Epilepsy / Seizures
☐ Stroke	☐ Multiple Sclerosis	☐ Parkinson's Disease
☐ Respiratory Problems	☐ Hernia	☐ Circulatory Disorder
☐ HIV / AIDS	☐ Peripheral Neuropathy	☐ Chest Pain / Angina
☐ Fractures Location:	☐ Cancer Location:	☐ Rheumatic Fever
		☐ Anemia
☐ Rheumatic Fever	☐ Congenital disorder	☐ Depression/Nervous Disorder
☐ Endocrine Disorder	☐ Asthma	☐ Allergies

2. List any prior / recent surgeries: _____

_____

_____

3. Are you currently pregnant? (Circle Yes or No) Yes / No NA

4. Are you currently taking any medications? If yes, please provide a list of names

_____

_____

5. Please rate your pain level by circling the number that best represents it

0 1 2 3 4 5 6 7 8 9 10
Best Worst

6. In the past 6-12 months, have you felt sad, depressed or lost interest in doing things? YES / NO
(Circle Yes or No)

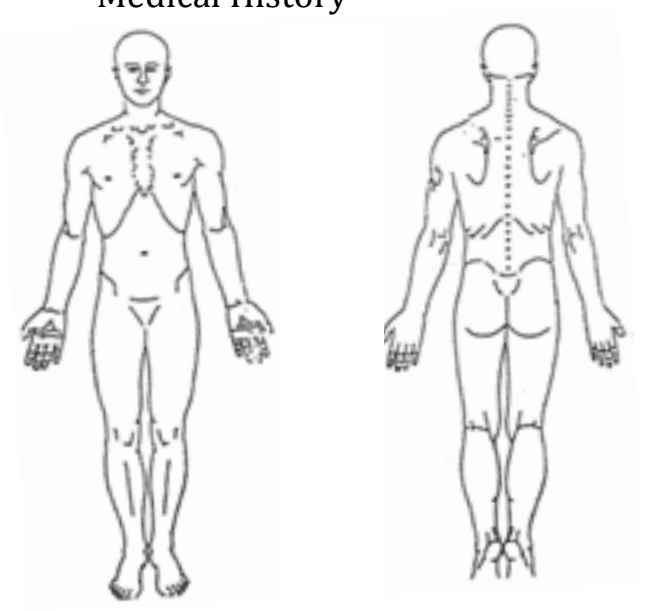
7. Do you have: (Circle Yes or No) Pacemaker YES / NO Metal Implants YES / NO
Cardiac Stents YES / NO

8. Please indicate, on the diagram below, the location of your pain, numbness or tingling is occurring.

Mi Therapy Clinic

Medical History

XXX = Pain
ooo = Numbness
−−− = Tingling
/// = Burning



Front **Back**

9. Since onset, are your symptoms getting: ☐ Better ☐ Worse ☐ Not changing

10. What type of pain are you experiencing?

☐ Throbbing ☐ Sharp ☐ Aching ☐ Tingling ☐ Burning ☐ Numbness

☐ Shooting ☐ Dull ☐ Constant ☐ Occasional

11. As the day progresses, do your symptoms:

☐ Increase ☐ Decrease ☐ Stay the same

12. Which activities increase your symptoms? _____

_____

13. What do you do to relieve your symptoms? _____

_____

14. Have you had any treatment for this condition in the past? ☐ Yes ☐ No
Please list all: _____

15. Have you received any of the following tests for this problem?

☐ X-ray ☐ MRI ☐ CT scan ☐ EMG ☐ Bone scan ☐ Nerve conduction study

☐ Other: _____ Results: _____

16. What are your goals and expectations for physical therapy? _____

_____

_____

Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____