Acct #: DOB:

Medical History – Check each of the topics that relate to your medical history

☐Allergies ☐Allergic to Latex ☐Amputation ☐Anemia
☐Angina ☐Asthma ☐Ataxia ☐Bell's Palsy
☐Bipolar ☐Blood Clot/Emboli ☐Bowel/Bladder Problems ☐Bronchitis
☐Carpal Tunnel Syndrome ☐Cellulitis ☐Cerebral Palsy ☐Concussion
☐COPD ☐Coronary Heart Disease ☐Depression ☐Dizziness or Faintness
☐Drink Alcohol ☐Emphysema ☐Energy Loss ☐Epilepsy/Seizures
☐Epstein-Barr ☐Gout ☐Guillain-Barre Syndrome ☐Headache, Severe
☐Hearing Difficulties ☐Heart Attack ☐Heart Disease ☐Hernia
☐High Blood Pressure ☐Intractable Pain ☐Kidney Disease ☐Lipedema
☐Low Blood Pressure ☐Low Blood Sugar ☐Lumpectomy ☐Lupus
☐Lyme Disease ☐Lymphedema ☐Mastectomy ☐Multiple Sclerosis
☐Neurological Issues ☐Osteoarthritis ☐Osteoporosis ☐Oxygen Dependency
☐Pacemaker ☐Parkinson's Disease ☐Pneumonia ☐Pregnancy, Current
☐Rheumatoid Arthritis ☐Sciatica ☐Shortness of Breath ☐Sleep Apnea
☐Sleeping Problems ☐Spinal Stenosis ☐Stroke/TIA ☐Thyroid
☐Tobacco Use ☐Torticollis ☐Varicose Veins ☐Vasculitis
☐Vertigo/Balance ☐Vision Difficulties ☐Weakness ☐Weight Loss
☐Women's Health Issue(s)

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Medical History – Check each of the topics that relate to your medical history

☐Abdomen ☐Ankle, Left ☐Buttock, Right ☐Feet/Toes, Left
☐Arm, Right ☐Buttock, Left ☐CRPS, Bilateral ☐Hands/Fingers, Left
☐Chest, Left ☐Chest, Bilateral ☐Elbow Right ☐Hip, Left
☐CRPS, Right ☐Elbow, Left ☐Hands/Fingers, All ☐Jaw, Left
☐Feet/Toes, Right ☐Hip, Both ☐Knee, Right ☐Knee, Both
☐Hands/Fingers, Right ☐Knee, Left ☐Lower Back, Left ☐Lower Back, Right
☐Hip, Right ☐Leg, Right ☐Neck, Left ☐Neck, Bilateral
☐Jaw, Right ☐Neck, Right ☐Upper Back, Left ☐Shoulder, Left
☐Leg, Left ☐Pelvis ☐Wrist, Right ☐Upper Back, Center
☐Lower Back, Center ☐Upper Back, Right ☐Arm, Left ☐None of these
☐Pelvic Floor ☐Wrist, Left ☐Chest, Right
☐Shoulder, Right ☐Ankle, Right ☐CRPS, Left

Medical History – Check each of the topics that relate to your medical history

☐Cancer ☐I am a caregiver for someone else ☐Infectious Disease
☐Pre-Diabetes ☐I live alone ☐My home has stairs
☐Diabetes, Type 1 ☐I use a cane ☐Other important issue(s)
☐Diabetes, Type 2 ☐I use a walker ☐Other surgery
☐I have received PT or OT at home ☐I use a wheelchair

Medical History – Check each of the topics that relate to your medical history

☐Joint replacement(s) ☐Arthritis ☐Pins or metal implant(s) ☐Numbness/Tingling

Located where: _____ Located where: _____

If you had previously checked the box that you have Arthritis- Where is it located?

☐Toes ☐Left ☐Right ☐Both
☐Ankle ☐Left ☐Right ☐Both
☐Calf ☐Left ☐Right ☐Both
☐Knee ☐Left ☐Right ☐Both
☐Thigh ☐Left ☐Right ☐Both
☐Hip ☐Left ☐Right ☐Both

☐Fingers ☐Left ☐Right ☐Both
☐Wrist ☐Left ☐Right ☐Both
☐Arm ☐Left ☐Right ☐Both
☐Shoulder ☐Left ☐Right ☐Both
☐Neck/Spine ☐Left ☐Right ☐Center

If you had previously checked the box that you have numbness/tingling-Where is it located?

☐Toes ☐Left ☐Right ☐Both
☐Ankle ☐Left ☐Right ☐Both
☐Calf ☐Left ☐Right ☐Both
☐Knee ☐Left ☐Right ☐Both
☐Thigh ☐Left ☐Right ☐Both
☐Hip ☐Left ☐Right ☐Both

☐Fingers ☐Left ☐Right ☐Both
☐Wrist ☐Left ☐Right ☐Both
☐Arm ☐Left ☐Right ☐Both
☐Shoulder ☐Left ☐Right ☐Both
☐Neck/Spine ☐Left ☐Right ☐Center

☐Check this box if you don't have any medical history to report
☐Check this box if you prefer not to report your medical history

How often do you exercise?

☐Never
☐Usually once per week
☐Usually twice per week
☐Usually 3 times per week
☐4 or more times per week

Does your daily routine, or work, aggravate your injury?

☐No
☐I am unable to participate in my normal routines or work
☐My routine/work usually impacts my injury 1 day per week
☐My routine/work aggravates my injury about 2 days per week
☐My routine/work aggravates my injury 3 or more days per week
☐My routine/work aggravates my injury every day, but I try to cope

Does your diagnosis impact your ability to do your job?

☐I am retired
☐The diagnosis prevents me from working
☐I can only work part time
☐I can work, but with great difficulty
☐I can work, with minor difficulty
☐The diagnosis does not impact my ability to work
☐Not applicable

Does your diagnosis impact your ability to attend school?

☐The diagnosis prevents me from attending school
☐I am in school, but the diagnosis has a big impact
☐I am in school and the diagnosis has a minor impact
☐School is normal, but I cannot participate in sports
☐School is normal, no impact
☐Not applicable

Please list any medications you are currently taking (Please include dose and frequency):

☐ **I am not taking any medications**
☐ **I will bring a list of my medications in**

Check the box below that prompted today's visit- Please select only one-main concern for today's visit:

☐Ankle, left
☐Ankle, right
☐Arm, left
☐Arm, right
☐Buttock, left
☐Buttock, right
☐Chest, left
☐Chest, right
☐CRPS, left
☐CRPS, right
☐Elbow, left
☐Elbow, right
☐Feet/toes, left
☐Feet/toes, right
☐Forearm, left
☐Forearm, right
☐Hands/fingers, left
☐Hands/fingers, right
☐Head, left
☐Head, right
☐Hip, left
☐Hip, right
☐Incontinence
☐Jaw, left
☐Jaw, right
☐Knee, left
☐Knee, right
☐Lower back, center
☐Lower back, left
☐Lower back, right
☐Neck, left
☐Neck, right
☐Pelvic floor
☐Shin/calf, left
☐Shin/calf, right
☐Shoulder, left
☐Shoulder, right
☐Spine
☐Thigh, left
☐Thigh, right
☐Upper back, center
☐Upper back, left
☐Upper back, right
☐Vertigo/balance
☐Wrist, left
☐Wrist, right

Please describe what type of pain you feel that also prompted this visit:

☐Aching ☐Burning ☐Constant ☐Cramping
☐Deep ☐Dull ☐Heavy ☐Numb
☐Pins & Needles ☐Stabbing ☐Throbbing ☐Variable
☐Weak

Please rate the level of pain/discomfort you are experiencing – Please circle one (10 Worst pain)

0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

☐Reaching back ☐Lying flat ☐Getting out of bed ☐Dressing and grooming
☐Cooking ☐Carrying items ☐Climbing stairs ☐Sitting
☐Twisting ☐Lifting anything ☐Lifting heavy weights ☐Pulling
☐Raising arm overhead ☐Looking up/down ☐Walking ☐Bending

What relieves your pain?

☐Ice ☐Heat ☐Stretching ☐Exercise
☐Pain medication ☐Lying flat ☐Avoiding activity ☐Nothing

Is this a recurrence of a previous injury or condition? ☐Yes ☐No
The year of your initial injury: _____

Have you had a recent surgery for the primary condition you are being seen for? ☐Yes ☐No
When was the surgery date? _____

Please enter height and weight:

Feet: _____ Inches: _____ Weight: _____

Falls- How many times have you fallen in the past year?

☐0 times ☐1 time ☐2 times ☐3 times ☐4 times
☐5 times ☐6 or more times

Were you injured: ☐ Yes ☐ No

About Depression: Over the last two weeks have you been bothered by feeling down, depressed, or hopeless?

☐Yes, I have been bothered by feeling down, depressed, or hopeless.

☐No, I have NOT

About Depression: Over the last two weeks have you been bothered by having little interest or pleasure in doing things?

☐Yes, I have been bothered by having little interest or pleasure doing things.

☐No, I have NOT

Your time and completion of this medical history form is greatly appreciated! Thank You