**Brief Medical History**

(Federal regulations require that a medical history must be included in all patients’ medical records)

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height:\_\_\_\_\_\_Weight: \_\_\_\_\_\_ Referring Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had occupational therapy for your present condition? Yes No When?\_\_\_\_\_\_\_\_\_\_Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Briefly describe how your condition occurred: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain/Symptoms**

On a scale from 0 to 10, (0 = no pain, 10 = high enough pain to go to the emergency room), what is your

**Current** pain level?\_\_\_\_/10 Your **highest** pain level? \_\_\_\_/10 Your **lowest** pain level?\_\_\_\_/10

List any factors that make your condition worse/better:

**Worse**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Better \_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the health conditions that apply to you:**

Anxiety/Panic Disorder

Asthma

Back Pain /neck pain, low back pain, degenerative disc diseases, and spinal stenosis

Cancer

Chronic Obstructive Pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS), or emphysema

Depression

Diabetes type 1 or 2

Fracture or suspected fracture

Gastrointestinal Disease /ulcer, hernia, reflux, bowel liver,

Headaches

Hearing impairment

Heart Disease / Heart Attack, Myocardial Infarction, Congestive heart failure, Pacemaker, Internal defibrillator, angina

Hepatitis/HIV/AIDS

High Blood Pressure

Kidney/ bladder, prostate, urination problems or incontinence

Neurological Disease

Osteoporosis

Peripheral Vascular Disease

Pneumonia (recent)

Previous Accidents

Prior surgery

Prosthesis/Implants or metal plates

Sleep Dysfunction

Seizures

Stroke/TIA

Thyroid

Visual impairments (such as cataracts, glaucoma, macular degeneration)

Other Disorders \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Females: Pregnant?** Yes No

gall bladder Alcohol Use: Never Rarely Moderate Daily

Tobacco Use: Never Quit Currently Smoke\_\_\_ Packs/day Year started smoking\_\_\_\_\_

If you checked any of the above conditions, please explain briefly and give approximate dates:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list current medicaitons you are taking:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Right Dorsal Right Volar Left Volar Left Dorsa**l



**On the arm diagram, please indicate your region of pain using the following symbols:**

**(X) Sharp**

**(+) Numbness/tingling**

**(#) Dull/aching**

**(B) Burning**

**Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**