ELYSIAN PHYSICAL THERAPY

Medical History Screen

Name: _____ **Primary Care Physician:** _____

Have you RECENTLY noted any of the following (check all that apply)?

_____changes in appetite _____dizziness/lightheadedness _____bowel or bladder function
_____fever/chills/sweats _____shortness of breath _____ headaches
_____difficulty maintaining balance while walking _____ weakness/fatigue
_____difficulty swallowing _____nausea/vomiting _____weight loss/gain

Have you EVER been diagnosed with any of the following conditions (check all that apply):

_____anemia _____asthma _____heart disease _____depression
_____high blood pressure _____rheumatoid arthritis _____diabetes _____osteoporosis
_____kidney/liver problems _____stomach ulcers _____chemical dependency (i.e., alcoholism)
_____lung problems _____stroke _____Parkinson's disease
_____multiple sclerosis _____thyroid problems _____cancer (type: _____)
_____epilepsy _____pacemaker (inserted) _____other:_____

During the past month have you been feeling down, depressed or hopeless? _____YES_____NO

During the past month have you been bothered by having little interest or pleasure in doing things?_____YES_____NO

Is this something with which you would like help? _____YES _____YES, but not today _____NO

Do you smoke? _____YES_____NO If yes, how many _____ pack(s) per day.

Height: _____ Weight: _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? _____YES_____NO

Please list current medications:

_____ ☐ *See Attached Rx List*

Are you currently taking blood thinner or anticoagulant medications for any medical conditions? _____YES_____NO

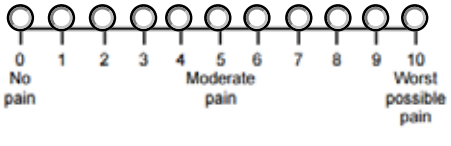
ALLERGIES: _____**Are you latex sensitive?** _____YES_____NO

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

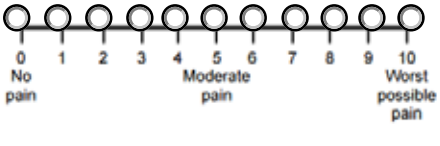
1. _____ 2._____ 3._____

PRESENT INJURY

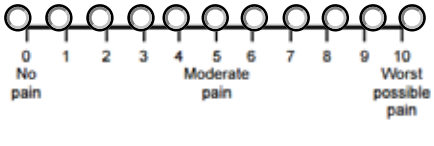
Rate your *LOWEST* pain level in PAST 3 DAYS:



Rate your pain *CURRENTLY* as of today:



Rate your *HIGHEST* pain level in PAST 3 DAYS:



Patient Signature: _____ Date: _____

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