DYNAMIC PHYSICAL THERAPY

MEDICAL HISTORY FORM

NAME: _____

CHECK THE BOXES THAT APPLY:

□Arthritis
□Allergies
□Blood Disorders
□Cancer
□Depression
□Diabetes
□High Blood Pressure
□Heart Problems
□Incontinence
□Seizures
□Neurological (stroke, MS)
□Fracture History_____
□Surgical History_____
□Other_____

MEDICATIONS:

_____ _____

_____ _____

_____ _____

CURRENT PAIN/PROBLEM:

Where is your pain or problem?_____

Approximately when did it start?_____

Is your pain getting: □BETTER □SAME □WORSE

Have you ever had this pain or problem before? □YES □NO
If yes, when? _____

What is your best/worst pain level? **□0 □1 □2 □3 □4 □5 □6 □7 □8 □9 □10**
(0 no pain, 2-3 mild, 4-7 Moderate, 8-10 Severe)

Are you taking medication for this problem? _____

Have you had an MRI, X-ray or CT Scan for this problem? _____

SIGNATURE DATE