TUNGSTEN™ Physical Therapy

Medical History Form

Please fill out form below prior to beginning of services. Thank you.

Patient Information

Patient Name: _____Date: _____Date of Birth:_____

Phone #: _____Email:_____

Address: _____City: _____Zip code:_____

Primary Care Physician: _____Phone #: _____Fax#:_____

Who Referred You? _____Phone #: _____Fax#:_____

Emergency Contact: _____Phone #_____

Personal History

Do you have difficulty with (please check all that apply):

☐ Hearing ☐ Vision ☐ Speech ☐ Communication

☐ Do you exercise regularly? How many days/week? What type of exercise?

☐ What is your body weight? Height? What is your ideal body weight?

Please list any allergies to medications you have:

Are you allergic to latex? ☐ Yes ☐ No Lotions or adhesives? ☐ Yes ☐ No

Please list or provide a copy of medications you are currently taking (dosage not necessary):

Please list any supplements and/or vitamins you are currently taking (dosage not necessary):

Please list any surgeries in your past:

Are you or suspect you could be pregnant? ☐ Yes ☐ No

Medical History- Do **you** have a history of: (Check all that apply)

- ☐ Asthma
- ☐ Allergies: _____
- ☐ Alcohol (Drinks/week): _____
- ☐ Smoking History(Packs/year): _____
- ☐ Assistive Device: _____
- ☐ Dizziness/Fainting
- ☐ Falls
- ☐ Stroke/CVA
- ☐ Prolonged use of steroid medications
- ☐ Pacemaker
- ☐ Headaches
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Shortness of breath
- ☐ Seizures
- ☐ Childhood Diseases: _____
- ☐ STDs: _____
- ☐ Anticoagulant medication
- ☐ Other: _____
- ☐ Other: _____

Medical History- Do **you or anyone in your family** have a history of: (Check all that apply)

Self	Family		Self	Family	
☐	☐	Diabetes	☐	☐	Smoking
☐	☐	Heart Disease	☐	☐	Chest pain
☐	☐	Heart Attack	☐	☐	Stroke/CVA
☐	☐	High Blood Pressure	☐	☐	Osteoporosis
☐	☐	High Blood Cholesterol	☐	☐	Osteopenia
☐	☐	Dizziness/Fainting	☐	☐	Rheumatoid Arthritis
☐	☐	Falls	☐	☐	Rhematic Disease
☐	☐	Recent trauma such as a car accident	☐	☐	Cancer (type): _____

Medical History in the **last 3 months** (Check all that apply):

- ☐ Diagnosed with a chronic musculoskeletal condition by a healthcare provider? If yes, by who? Please describe:
- ☐ Unexplained change in your health? Please describe: _____
- ☐ Explained illness or injury? Please describe: _____
- ☐ Unexplained weight loss or gain?
- ☐ Night chills, sweats, or fever?
- ☐ Changes in bowel function?
- ☐ Fever or recent surgery? Please describe:
- ☐ Numbness or tingling Please describe:
- ☐ Changes in bladder function?

Medical Screen

Please use the diagram to indicate where you feel symptoms right now

Sharp/Stabbing= xxxx Deep Ache = /////

Numbness/Tingling= ooo Burning= zzzzzz

On a scale 0-10 what would you rate your:

Current pain:

Best (last 2 weeks):

Worst pain rating (last 2 weeks):

(0=no pain, 10= worst pain imaginable)

What makes your pain worse?

What makes your pain better?

Are your symptoms:

☐ Getting worse ☐ Same ☐ Improving

How are you sleeping at night? (Check one)

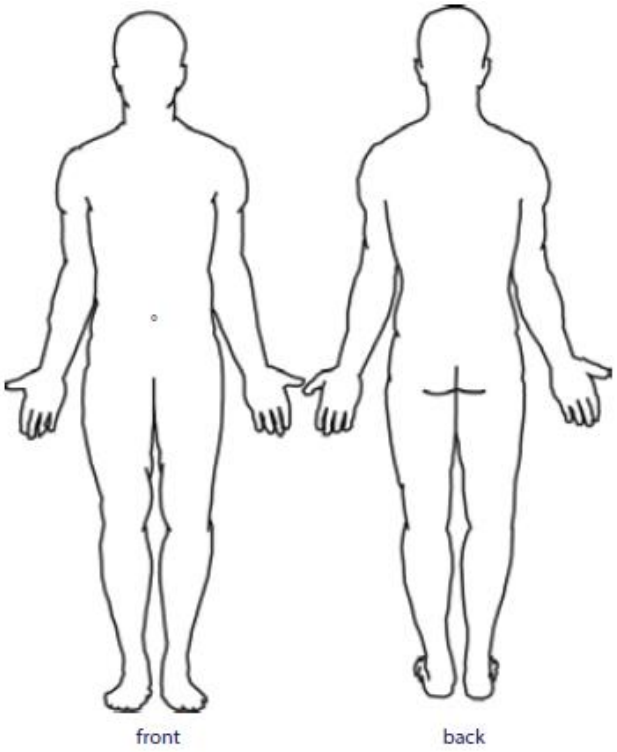
☐ Good ☐ Moderate ☐ Poor

When did your problem begin? (date):

Have you been treated for this condition before?

☐ Yes ☐ No

When? How?



General Consent

_____ Initials	I hereby consent, voluntarily, to participate in physical therapy, nutrition counseling, personal training, wellness program, or any other treatment within the scope of practice of the provider affiliated with Tungsten™ Physical Therapy. I understand that I may elect to stop this program at any time. I understand that there is a risk associated with any of the aforementioned treatments of either temporary or permanent injury or death. I have been honest and thorough in my medical history. A physical therapy diagnosis is not a medical diagnosis by a physician and is not based on radiological imaging. Tungsten™ Physical Therapy does not directly bill third party payers, but will provide a receipt at your request. These services may or may not be covered by your health plan or insurer.		
_____ Initials	I have been given an opportunity to review the HIPAA Privacy Policy. I would like a printed copy.	☐ Yes	☐ No
_____ Initials	I agree to pay the full session fee for failing to arrive at a schedule appointment or if a 24 hour notice is not given prior to cancellation.		
_____ Initials	TUNGSTEN™ Physical Therapy uses text messaging, cell phone calls, email and social media to communicate with its patients and provide educational programming. I give informed consent to the use of the aforementioned methods.		

Additional Information

Please use this space to provide us with any additional information:

Patient or Representative Signature:	Date: