Hands On
Physical Therapy, PLLC

MEDICAL HISTORY

Date: _____

1. Name: _____

2. Present Problem(s):

_____

_____

_____

_____

3. Current Health:

- ☐ Migraines
- ☐ Glasses/Contacts
- ☐ Scoliosis
- ☐ Smoker/Tobacco user
- ☐ Alcohol
- ☐ Caffeine
- ☐ Heart Problems:
  - ☐ Chest Pain
  - ☐ Races
  - ☐ Skips Beats
  - ☐ Murmurs
  - ☐ A-Fib
- ☐ Frequent Headaches
- ☐ Shortness of Breath
- ☐ Irritable Bowel
- ☐ Constipation
- ☐ Diarrhea
- ☐ Incontinence
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Orthotics

Other: _____

_____

4. Past history/Symptoms:

☐ Neck pain
☐ Mid back pain
☐ Low back pain
☐ Concussion or hit your head
☐ Headaches
☐ Disc problems
☐ Dental work

Other: _____

_____

5. Diseases:

☐ Hepatitis
☐ HIV+
☐ Osteoporosis
☐ Epstein Bar
☐ Allergies
☐ Chrohn's Disease
☐ Multiple Sclerosis
☐ Diabetes
☐ Cancer
☐ Arthritis
☐ Fibromyalgia
☐ Asthma
☐ Lyme's Disease
☐ Thrombophlebitis
☐ Thyroid
☐ Neuropathy
☐ Lymphangitis
☐ Restless Leg Syndrome
☐ Stroke
☐ High Blood Pressure

Other: _____

_____

6. Women Only:

☐ Hysterectomy
☐ Miscarriage(s)
☐ Irregular menstruation
☐ Endometriosis
☐ C-section
☐ Vaginal birth
☐ Severe cramps
☐ Menopause

Other: _____

_____

7. Operations/Surgeries:

a. _____ Date: _____

b. _____ Date: _____

c. _____ Date: _____

d. _____ Date: _____

8. Current Medications:

a. _____

b. _____

c. _____

d. _____

9. Accidents/Injuries (Past & Present):

a. _____ Date: _____

b. _____ Date: _____

c. _____ Date: _____

d. _____ Date: _____

10. Have you ever been unconscious either by accident or medicated? ☐ Yes ☐ No

11. Please mark the body with areas of pain and rate your pain on a scale of 0-10,
(0 is no pain and 10 means you need to be taken to the hospital)