DYNATEST, INC.

Medical History Form

Patient Name:____ **Age:**_________________
Height:__________ **Weight:**__________

Accident Information: **Date of Accident:**_____/_____/_____
Are you here today due to an accident? Yes/No Was the accident work related? Yes/No
Was the accident a result of a Motor Vehicle Accident (MVA)? Yes/No
Give a brief description of how the accident occurred:____
____
____

What are we treating you for today? (please indicate body part)_______________________________
What is your pain level? **1 2 3 4 5 6 7 8 9 10**

What goals would you like to accomplish with your therapy treatment?________________________
____

Please list all medication: (please see attached list: __yes __no)
____________________ ____________________ ____________________
____________________ ____________________ ____________________

Past Medical History – Do you have a history of…(mark all that apply)

__High Blood Pressure	__Cancer	__Muscle Weakness
__Heart Condition	__Osteoarthritis	__Muscular Sclerosis
__Stroke	__Diabetes	__Internal Fixation Device
__Pacemaker	__Fibromyalgia	__Artificial Joint________________
__Seizure	__Currently Pregnant	(please indicate which joint)

Do you smoke or are you a former smoker? __Daily __Occasionally __ Quit __No

Previous surgeries: __yes __no (if yes, please specify the procedure and when it took place)
____

Have you had Home Health Care? __yes __no
If yes, please indicate the date of discharge: _____/_____/_____**this would include any type of home visit care (i.e. nurse visits, wellness checks, home therapy, etc.)
The answer is important as Medicare will not pay for physical therapy if the patient is currently under home health care. If you answer no and Medicare denies your claim or recoups your claim payment due to being under home health care, you will be held financially responsible for the claims.

Current activity/exercise level:
__0 days/week __1-2 days/week __3-5 days/week __6-7 days/week
Type of activity/exercise:____

****The above information is complete, correct, and true to the best of my knowledge****
Patient/Guardian Signature:____
Date of Signature:_____/_____/_____
****
Therapist Signature:____