PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: _____

Have you had a related surgery? ☐ Yes ☐ No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:	☐	☐	Stroke/CVA	☐	☐

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No

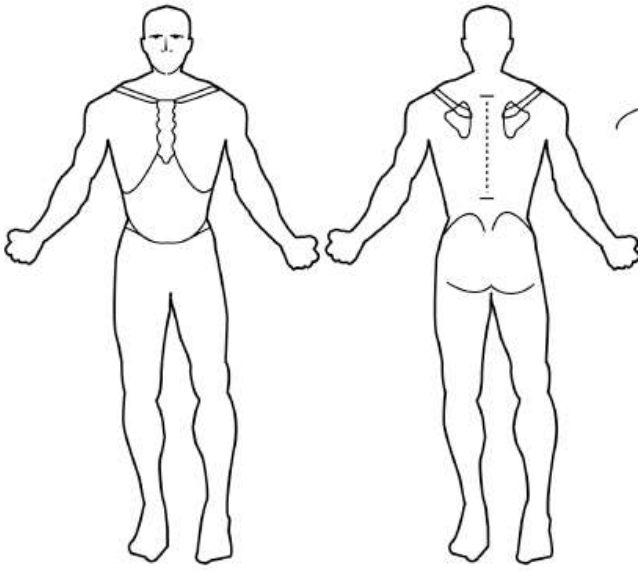
If yes, please list what medications and for what condition:

In case of an emergency, whom should we contact?

Name: _____
Phone Number: _____

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe _____

Please indicate below where your symptoms are located.



KEY:

Numbness: = = = = = = = = =

Pins & Needles: ooooooooo

Burning Pain: xxxxxxxxxxx

Stabbing Pain: //////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

_____ ____/____/____
Patient's Signature Date

_____ ____/____/____
Signature of Guardian if patient is a minor Date

_____ ____/____/____
Therapist Signature Date