Monarch Physical Therapy
Medical History/Subjective Information

Name: _____ DOB: _____ Date: _____

Reason for PT: _____

Onset/Surgery date: _____ Referring MD: _____

Physical therapy **GOALS**: Please describe the activities you would like to be able to do easier.

_____

Do you/did you have a regular exercise program? □ No □ Yes What type? _____

_____

HEALTH SCREEN/MEDICAL DIAGNOSES OR CONDITIONS: Check any of the problems that apply to **YOU.**

Musculoskeletal
□ Arthritis
□ Osteoporosis
□ Rheumatoid Arthritis
□ Broken bones _____
□ Fibromyalgia
□ Other bone/joint injuries: _____

Spine
□ Scoliosis / curvature of the spine
□ Lower back pain
□ Neck pain
□ Disc bulge / herniation / degeneration

Psychosocial / Mental Illness
□ Depression
□ Anxiety

Cardiovascular
□ High blood pressure
□ Congestive heart failure
□ Smoking
□ Pacemaker
□ Heart attack

Neurological
□ Stroke / CVA
□ Parkinson's Disease
□ Multiple Sclerosis
□ Epilepsy / Seizures
□ Memory loss
□ Head injury

Blood Disorders
□ Anemia
□ Leukemia
□ Blood clot

Lungs
□ Asthma
□ COPD / Emphysema
□ Pneumonia

Nutrition Screen
□ Appetite loss
□ Difficulty swallowing
□ Weight loss > 10 lbs.

Reproductive/Bowel/Bladder
□ Renal failure
□ Incontinence/Leaking
□ Hysterectomy
□ Pregnant □ No □ Yes □ N/A

Vision / Hearing
□ Visual impairment
□ Difficulty hearing

Skin
□ Open areas/wounds
□ Rashes / sensitivities

General
□ Dizziness
□ Falls
□ Headaches / migraines
□ Chills
□ Night pain / sweats
□ Numbness / tingling
□ Other: _____

Allergies
□ Medications: Please list: _____
□ Latex
□ Adhesives

Cancer/Oncology **Type:** _____
Date of diagnosis:_____ Treatment:_____
Radiation: □ No □Yes When? _____ Chemo: □No □Yes When? _____
Do you have a port: □No □Yes Where? _____

Other medical problems: □ N/A _____

Please continue on the next page

Hx form reviewed by: _____

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SURGERIES (**Please list with dates)**	

MEDICATIONS (Please include dosage) □ **See attached sheet**	

VIOLENCE / ABUSE: We recognize the serious consequences of violence and abuse. Would like to have information about agencies or individuals that could assist you or a family member? □ No □ Yes

CULTURE / RELIGION: Do you have any cultural of religious beliefs that may affect your care? □ No □ Yes
Please describe: _____

COMMUNICATION: What is the best way to communicate with you regarding appointment reminders, schedule changes, etc?

□ Home phone □ Cell phone □Email: _____

Is it ok for a message to be left on voicemail: □ No □ Yes

PHOTO RELEASE: Will you allow photos/videos to be taken for educational purposes? Your identity will not be revealed. □ No □ Yes

EMERGENCY CONTACT INFORMATION: In case of an emergency, who should we contact?

Name: _____ Phone: _____

Relationship: _____

_____ _____
Patient signature Date

_____
Patient name printed

Hx form reviewed by: _____