Medical History – Check each of the topics that relate to your medical history

☐Anemia	☐A pacemaker	☐Allergies
☐Back Pain	☐Angina	☐Asthma
☐Bronchitis	☐Blood clot/Emboli	☐Bowel/bladder problems
☐Dizziness/faintness	☐Coronary Heart Disease	☐Currently pregnant
☐Epilepsy/Seizures	☐Drink Alcohol	☐Emphysema
☐Heart attack	☐Gout	☐Hearing difficulties
☐Kidney disease	☐Hernia	☐High blood pressure
☐Severe/freq. headache	☐Parkinson's	☐Pneumonia
☐Stroke/TA	☐Sleeping problems	☐Smoke cigarettes
☐Vision difficulties	☐Thyroid problems	☐Varicose veins
☐Women's health issues	☐Weakness	☐Weight loss/energy loss

Medical History – Check each of the topics that relate to your medical history

☐Ankles, both	☐Ankle, left	☐Ankle, right
☐Elbows, both	☐Elbow, left	☐Elbow, right
☐Hips, both	☐Hip, left	☐Hip, right
☐Knees, both	☐Knees, left	☐Knees, right
☐Legs, both	☐Leg, left	☐Leg, right
☐Shoulders, both	☐Shoulder, left	☐Shoulder, right
☐Wrist, both	☐Wrist, left	☐Wrist, right

Medical History – Check each of the topics that relate to your medical history

☐Joint replacement ☐Arthritis ☐Pins or metal implant ☐Numbness/Tingling

Located where: _____ Located where:_____

Medical History – Check each of the topics that relate to your medical history

☐Complex regional pain syndrome	☐Cancer	☐Diabetes, type 1
☐Diabetes, type 2	☐Vertigo/balance	☐Infectious disease
☐Other surgery	☐Incontinence	☐Pelvic floor issues
☐I live alone	☐I use a cane	☐I use a wheelchair
☐I use a walker	☐My home has stairs	
☐Other important issues	☐I have received PT at home	
☐I am a caregiver for someone else		

☐Check this box if you don't have any medical history to report

☐Check this box if you prefer not to report your medical history

Does your diagnosis impact your ability to do your job?

☐I am retired	☐The diagnosis prevents me from working
☐I can only work part time	☐I can work, but with great difficulty
☐I can work, with minor difficulty	
☐The diagnosis does not impact my ability to work	
☐Not applicable	

Does your diagnosis impact your ability to attend school?

☐The diagnosis prevents me from attending school

☐I am in school, but the diagnosis has a big impact

☐I am in school and the diagnosis has a minor impact

☐School is normal, but I cannot participate in sports

☐School is normal, no impact

☐Not applicable

How often do you exercise?

☐Never
☐Usually once per week
☐Usually twice per week
☐Usually 3 times per week
☐4 or more times per week

Does your daily routine, or work, aggravate your injury?

☐No
☐I am unable to participate in my normal routines or work
☐My routine/work usually impacts my injury 1 day per week
☐My routine/work aggravates my injury about 2 days per week
☐My routine/work aggravates my injury 3 or more days per week
☐My routine/work aggravates my injury every day, but I try to cope

If you had previously checked the box that you have Arthritis- Where is it located?

☐Toes ☐Left ☐Right ☐Both
☐Ankle ☐Left ☐Right ☐Both
☐Calf ☐Left ☐Right ☐Both
☐Knee ☐Left ☐Right ☐Both
☐Thigh ☐Left ☐Right ☐Both
☐Hip ☐Left ☐Right ☐Both

☐Fingers ☐Left ☐Right ☐Both
☐Wrist ☐Left ☐Right ☐Both
☐Arm ☐Left ☐Right ☐Both
☐Shoulder ☐Left ☐Right ☐Both
☐Neck/Spine ☐Left ☐Right ☐Center

If you had previously checked the box that you have numbness/tingling-Where is it located?

☐Toes ☐Left ☐Right ☐Both
☐Ankle ☐Left ☐Right ☐Both
☐Calf ☐Left ☐Right ☐Both
☐Knee ☐Left ☐Right ☐Both
☐Thigh ☐Left ☐Right ☐Both
☐Hip ☐Left ☐Right ☐Both

☐Fingers ☐Left ☐Right ☐Both
☐Wrist ☐Left ☐Right ☐Both
☐Arm ☐Left ☐Right ☐Both
☐Shoulder ☐Left ☐Right ☐Both
☐Neck/Spine ☐Left ☐Right ☐Center

Please list any medications you are currently taking:

☐ I am not taking any medications

Check the box below that prompted today's visit- Please select only one-main concern for today's visit:

☐Ankle, left
☐Ankle, right
☐Arm, left
☐Arm, right
☐Buttock, left
☐Buttock, right
☐Chest, left
☐Chest, right
☐CRPS, left
☐CRPS, right
☐Elbow, left
☐Hands/fingers, left
☐Hands/fingers, right
☐Head, left
☐Head, right
☐Hip, left
☐Hip, right
☐Incontinence
☐Jaw, left
☐Jaw, right
☐Knee, left
☐Knee, right
☐Pelvic floor
☐Shin/calf, left
☐Shin/calf, right
☐Shoulder, left
☐Shoulder, right
☐Spine
☐Thigh, left
☐Thigh, right
☐Upper back, center
☐Upper back, left
☐Upper back, right

☐Elbow, right
☐Feet/toes, left
☐Feet/toes, right
☐Forearm, left
☐Forearm, right
☐Lower back, center
☐Lower back, left
☐Lower back, right
☐Neck, left
☐Neck, right
☐Vertigo/balance
☐Wrist, left
☐Wrist, right

In the box you checked above-Was this pain a reoccurrence of a prior injury? ☐Yes ☐No
If yes, what year was the prior injury? _____

Please describe what type of pain you feel that also prompted this visit:

☐Aching ☐Heavy ☐Burning ☐Numbness
☐Constant ☐Pins and needles ☐Cramping ☐Stabbing
☐Deep ☐Throbbing ☐Dull ☐Variable ☐Weak

Describe your pain level when your symptoms began – Please circle one (10 Worst pain)

0	1	2	3	4	5	6	7	8	9	10

Describe your pain level when it is at its worst - Please circle one (10 Worst pain you have had)

0	1	2	3	4	5	6	7	8	9	10

Describe your pain level when you feel best – Please circle one

0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

☐Reaching back ☐Twisting ☐Lying flat ☐Lifting anything
☐Cooking ☐Carrying items ☐Pulling ☐Getting up out of bed
☐Lifting heavy weights ☐Climbing stairs ☐Walking ☐Looking up/down
☐Raising arm overhead ☐Lifting light weights ☐Dressing/Grooming

What relieves your pain?

☐Ice ☐Heat ☐Stretching ☐Exercise
☐Pain medication ☐Lying flat ☐Avoiding activity ☐Nothing

Please enter height and weight:

Feet: _____ Inches: _____ Weight: _____

Falls- How many times have you fallen in the past year?

☐0 times ☐1 time ☐2 times ☐3 times ☐4 times
☐5 times ☐6 or more times

Were you injured: ☐ Yes ☐ No

Tobacco Use:

About tobacco usage, Do you

☐Smoke tobacco ☐Chew tobacco ☐Snuff tobacco ☐All of the above ☐ None of the above

Have you ever received advice or counseling to help you stop using tobacco?
☐Yes, I have received advice and/or counseling
☐No, I have not received advice and/or counseling

Your time and completion of this medical history form is greatly appreciated! Thank You