Perform for Life
Physical Therapy
• PERFORM BETTER. LIVE BETTER •

Patient Confidential Medical History Form

Last Name: _____First Name: _____ Today's Date: ___/___/___

DOB: ____/_____/_____ Hand dominance: R/L Height: _____ Weight:_____

Does your home have stairs? Y/N Do you live alone? Y/N

How many days per week do you exercise for 30 minutes or more? 0 1-3 4-5 6-7

Involved Activities: _____

Emergency Contact: _____Relationship: _____Telephone: _____

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Reason for today's visit: _____

Briefly describe how your problem began: _____

Date of Onset: ___/___/_____ Date of Surgery: ___/___/_____ Type of Surgery: _____

Diagnostic Tests: (Circle all that apply) X-rays Bone Scans Ultrasound MRI Other: _____

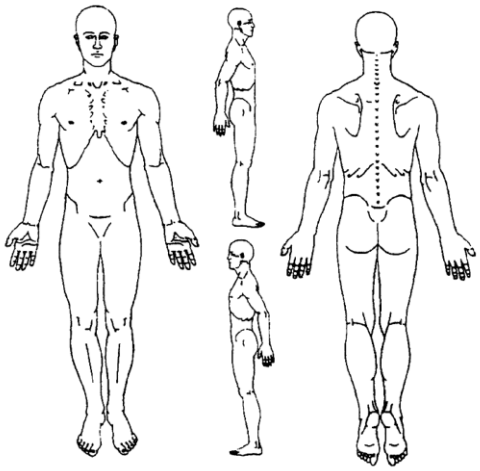
Prior treatments for the current complaint: (Circle all that apply) □ **No treatment received yet**

Physical Therapy	Chiropractic Care	Pain Management	Massage	Injections
Aquatic Therapy	Surgical Intervention	Bracing/Tape	Acupuncture	Massage

Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst pain you can imagine):

Best: 0 1 2 3 4 5 6 7 8 9 10 Worst: 0 1 2 3 4 5 6 7 8 9 10 Current: 0 1 2 3 4 5 6 7 8 9 10

Please Circle areas of complaint:



Describe your symptoms:

□ sharp □ dull □ aching □ throbbing □ burning □ sore □ weak
□ shooting □ stabbing □ squeezing □ constant □ intermittent
□ other: _____
What makes it worse?_____
What makes it better? _____
Does time of day affect your pain? _____
Does pain wake you from your sleep? _____
Do you have any numbness or loss of sensation? No Yes
If Yes, where?_____
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Check if you currently have or had in the past:

□ If returning and nothing has changed, check here.

□ Acid Reflux
□ Asthma
□ Bowel/Bladder Dysfunction
□ Cancer (site:________)
□ Cardiac Bypass/stents
□ Chest pain/Angina
□ COPD
□ Depression
□ Diabetes
□ Dizziness/Fainting
□ Emphysema
□ Epilepsy/Seizures
□ Fibromyalgia
□ Headaches or Migraines
□ Heart Disease/Attack
□ High Blood Pressure
□ High Cholesterol
□ HIV/AIDS
□ Kidney Disease
□ Lupus
□ Lyme Disease
□ Osteoarthritis
□ Osteoporosis/Osteopenia
□ Pacemaker
□ Parkinson's Disease
□ Rheumatoid Arthritis
□ Scoliosis
□ Stroke
□ Currently Pregnant (# wks___)
□ Other: _______________

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Have you had any falls in the past year? Y/N If yes, how many and describe: _______________________

Do you use any of the following: Cane Walker Wheelchair Crutches

Circle any that you may have/wear: Glasses Contacts Pacemaker Metal Implant Hearing Aids

List all previous surgeries (past 10 years):

____
____
____
____

Please list all allergies: ____

Current Medications: (Please list dose, frequency, and reason for each)

____
____
____
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To the best of my ability, I certify above information to be true.

Patient/Guardian Signature: ____ Date:_____________________

Reviewed by Therapist.

Therapist Signature: ____ Date: _____________________
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