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:______ Do you live alone? Y/N

Occupation: _______________ Does your home have stairs? Y/N Do you smoke? Y/N
Alcohol use: □ Daily □ Weekly # of drinks: ___________

Regular exercise/activity level per week ___0 days ___1-3 days ___4-5days ___6-7 days
Involved Activities: ____

Doctors: Orthopedic ______________ Primary Care ____________________ Cardiologist ________________

Neurologist _______________ Endocrinologist __________________ Other _____________________

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: □ X-rays □ Bone Scans □ MRI □ Other: ___________

Prior treatments for the current complaint: □ **No treatment received yet**

□ Physical Therapy □ Chiropractic □ Pain Management □ Massage □ Acupuncture

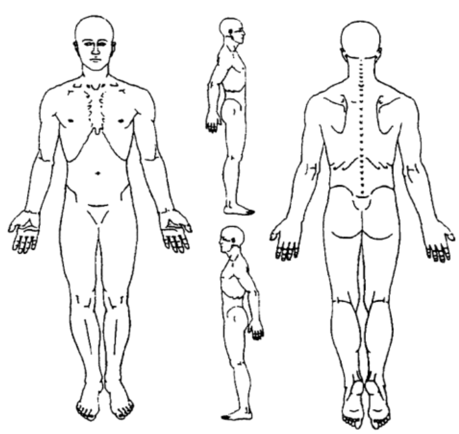
Please rate your pain on 0-10 scale (0 is no pain, 10 is the worst pain you can imagine):

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

In what ways do you feel your injury or condition has affected you? _________________________________

____

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 or Circle if you currently have or had in the past:

□ If returning and nothing has changed, check here.

□ Acid Reflux	□ Epilepsy/Seizures	□ Osteoarthritis
□ Asthma	□ Fibromyalgia	□ Osteoporosis/Osteopenia
□ Bowel/Bladder Dysfunction	□ Headaches/Migraines	□ Pacemaker
□ Cancer (site:______________)	□ Heart Disease/Attack	□ Parkinson's Disease
□ Cardiac History	□ High Blood Pressure	□ Recent Infection
□ Chest pain/Angina	□ High Cholesterol	□ Rheumatoid Arthritis
□ COPD/emphysema	□ HIV/AIDS	□ Stroke
□ Depression/Anxiety	□ Kidney Disease	□ Currently Pregnant # wks___
□ Diabetes (Type I or II)	□ Lyme Disease	□ Other: ________________
□ Dizziness/Fainting	□ Multiple Sclerosis	

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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):

____

____

____

____

Previous Orthopedic Problems? If yes, did you have PT? ____

Please list all allergies: ____

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

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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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