BONNEY LAKE
Physical Therapy & Hand Rehab, PLLC

Brief Medical History

Please Print Clearly

Patient Name:______________________________DOB:__________ Injury/Onset date:_________Surgery date:_________

Street Address:____City, State, Zip:_______________________________

Contact phone:______________________(cell/home) Other Number / parent:_________________________ (cell/home)

E-mail address:____Sex: F / M Marital Status: M__ S__ W__ D__ O__

Emergency Contact/Guardian/Power of Attorney _________________________Phone_______________Relation:_________

List all Doctors/Medical Providers: ____

Accident related? Y/N Auto: Y/N On someone elses Property: Y/N Attorney/phone: ________________________

Hand Dominance: Right / Left **Height:**______**Weight:**_______

How many falls in the past 12 months?_____ **Falls with Injuries?**____________

Current Medications: ____

____

Medication/Vitamin/Supplement List Attached____ (MEDICARE requires name, dosage, frequency & type)

Allergies/Sensitivity: Medications/Lotions/Fragrances/Latex/Heat or ice ________________________

Pain scale "0-10": (0 = no pain - 10 = Excruciating): Now:_____ Rest:_____Activity:_____

List 3 difficult activities due to your condition/injury **0= No Difficulty 10=Unable to Perform Activity**

1 _____________________________ **Impairment Rating (0-10)** _____

2 _____________________________ **Impairment Rating (0-10)** _____

3 _____________________________ **Impairment Rating (0-10)** _____ **(Office Use: Score______)**

Employment: Full Time / Part Time / Homemaker / Retired / Disabled / Student / Unemployed Employer: ______________

If employed; Job Title & Duties: ____

Goals for Therapy: ____

Please indicate any conditions you have now or in the past:

Condition				Condition		
Diabetes	Yes / No	Controlled	Yes / No	Tobacco use: Smoke/Chew/Electronic?		Yes / No
High Blood Pressure	Yes / No	Controlled	Yes / No	Asthma Yes / No	Controlled	Yes / No
Heart Disease / Attack			Yes / No	Lung / Pulmonary Disorders		Yes / No
Pacemaker			Yes / No	Pregnancy:	Current	Yes / No
Circulatory Disorders: Cardiac/Extremity			Yes / No	Cancer: Type	______________	Yes / No
TMJ Disorders			Yes / No	Other Illness: list	______________	Yes / No
Headaches/Migraine			Yes / No	Previous Accidents: Auto/Work		Yes / No
Nervous Disorders			Yes / No	Surgeries (non-orthopedic)	list below	Yes / No
CVA / Stroke			Yes / No	Hernia: Inguinal / Umbilical / Hiatal	Any surge	Yes / No
Head Injury/Concussion/TBI/CHI			Yes / No	Skin conditions / wounds / rashes		Yes / No
Forgetfulness			Yes / No	Orthopedic injuries/concerns (Spine/extremity)		Yes / No
Depression/Emotional/Suicidal thoughts			Yes / No	Orthopedic Implants or Artificial Joints		Yes / No
Dizziness/Vertigo/Seizures			Yes / No	Orthopedic Surgeries:	list below	Yes / No
Eye problems, Blurred vision, Cataracts			Yes / No	Arthritis: list affected joints		Yes / No
Kidney Disorders			Yes / No			

Please list / explain any above: ____

____

____

____

Previous treatment(s) for condition: Y / N (If yes, please explain)____

The undersigned acknowledges and agrees that the above information is true and correct.

Signature____ **Date**_____________________