MEDICAL HISTORY FORM

PATIENT NAME: ___________________________________ TODAY'S DATE: _____________________________
REFERRING PHYSICIAN'S NAME: ____________________ INJURY DATE/ONSET: ________________________
CAUSE OF INJURY OR ONSET: _______________________ ARE YOU PRESENTLY WORKING: YES/NO
PRIMARY CARE PHYSICIAN'S NAME: ________________ NEXT MD APPT: _____________________________

WHAT IS YOUR REASON FOR ATTENDING THERAPY: ____

WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. ____
2. ____
3. ____

WHAT ARE YOUR PERSONAL GOALSIOUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. ____
2. ____
3. ____

WHAT IS YOUR HEIGHT? ___________________ WHAT IS YOUR WEIGHT? _____________

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES / NO IF YES, HOW MUCH? _________________________________

HAVE YOU RECENTLY BEEN HOSPITALIZED? YES / NO IF YES, WHEN? _______________________________

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION? (circle one) YES / NO
WHAT WAS DONE / WHAT WERE THE RESULTS: ____
HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES / NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? ____

ALLERGIES: ____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

☐ ANEMIA ☐ DEPRESSION ☐ HEPATITIS/HIV ☐ CURRENTLY PREGNANT
☐ ASTHMA ☐ DIZZINESS ☐ FAINTING ☐ KIDNEY PROBLEMS
☐ SEIZURES ☐ CANCER ☐ FRACTURES ☐ LOW BLOOD PRESSURE
☐ SUBSTANCE ABUSE ☐ HEART PROBLEMS ☐ HEADACHES ☐ METAL IMPLANTS
☐ THYROID PROBLEMS ☐ PACEMAKER ☐ OSTEOPEROSIS ☐ DIABETES
☐ RESPIRATORY PROBLEMS ☐ HIGH BLOOD PRESSURE (☐ Controlled ☐ Uncontrolled)
☐ RECENT FALL(s) (_______ IN THE PAST 3 MTHS) ☐ INCONTINENCE

☐ ANY OTHER MEDICAL PROBLEMS: ____
____
____
____
____

MEDICAL HISTORY FORM

TODAY'S DATE: ______________________________

The medicines you take are part of your health information. Please fill out this form (or have your caregiver complete it). If you need more space to fill in your medications, please ask for another form. Please do not write on the back of this form.

● ALLERGIES

Name of Substance (drug or food)	**Type of Reaction**

● Current Medications

Prescription Drugs (including eye drops, creams)	**Strength** (such as 50 mg)	**Directions** (such as 2 tablets in a.m.) *Check box if taken only as needed*	**Prescribed By** (such as John Doe, MD

Over-the-Counter Medications (such as aspirin)	**Strength**	**Directions** (such as for headaches, when needed.)

Herbs, Vitamins, Minerals, etc. (such as Vit. C.)	**Strength**	**Directions** (such as 1 Tablet each day.

SIGNATURE OF PATIENT: ________________________________ REVIEWED BY: ________________________