



Patient Medical History

Name: _____ Date: _____

Referring Doctor: _____ Primary MD: _____

Please list any medications you are currently taking (including pills, injections, and/or skin patches):

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Please list any medications you are allergic to: _____

Has your Physician ordered any tests for this diagnosis? _____ (yes) _____ (no)

If yes, please circle: X-ray CT Scan MRI EMG Nerve Conduction Velocity

Results: _____

Please circle if you have had any of the following:

- | | | |
|------------------------|---------------------|--------------------------|
| Anemia | Allergies | Arthritis |
| Asthma | Bladder Problems | Blood Clots |
| Bowel Problems | Bronchitis | Cancer |
| Chemotherapy | Chest Pain | Congestive Heart Disease |
| Coronary Heart Disease | Diabetes | Dizziness |
| Epilepsy | Fainting | Gout |
| Heart Attack | Heart Surgery | Headaches |
| Hernia | High Blood Pressure | Infectious Disease |
| Osteoporosis | Pacemaker | Pins/Metal Implants |
| Psychological Problems | Radiation | Shortness of Breath |
| Sleeping Problems | Stroke | Thyroid Disease |
| Varicose Veins | Weakness | Weight/Energy Loss |

Are you pregnant? _____(yes) _____ (no) Do you use Tobacco? _____(yes) _____(no)

What are your goals for physical therapy? _____

Is there any other information we should know regarding your care?

Using the 0 to 10 pain scale, with 0 being "no pain" and 10 being "the worst pain imaginable" please describe:

Current level of pain _____ Best level of pain in the last 24 hours _____ Worst level of pain in the last 24 hours _____

Patient/Guardian Signature _____ Date _____