 **Medical History Form** Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_

Patient name: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred name: (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Pronoun: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Check all that apply:

□ Diabetes □ Heart Condition □ High Blood Pressure □ Dizziness
□ Seizures □ Cancer/Tumor □ Rheumatoid Arthritis □ Osteoarthritis
□ Osteopenia □ Osteoporosis □ Depression/Anxiety □ Asthma
□ Edema □ Thyroid Disorder □ Fibromyalgia □ Latex Allergy
□ Pacemaker □ Recent weight loss □ Change in bowel/bladder □ Anaphylaxis
□ Pregnancy – wks \_\_\_\_\_ □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries you have had: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications/supplements you currently take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your primary reason for seeking physical therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your symptoms:

□ Ache □ Numbness/tingling □ Dull pain □ Sharp pain
□ Shooting □ Throbbing □ Burning □ Other \_\_\_\_\_\_\_\_\_\_

Please rate your pain ( 0= no pain; 10=worst possible pain)

|  |
| --- |
| 0 1 2 3 4 5 6 7 8 9 10 |

 No pain Moderate pain Worst possible pain


Please mark the body chart with an X in the areas of pain

List any additional health information you would like us to know:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_