PHYSICAL THERAPY MEDICAL HISTORY

Date: ____ / ____ / ____

PATIENT INFORMATION

Name (Last)   First (MI)

Prescription Medications/Supplements: ________________________

CURRENT SYMPTOMS

Check all that apply

☐ Chest pain
☐ Coordination problems
☐ Decreased range of motion
☐ Difficulty concentrating
☐ Difficulty sleeping
☐ Headaches
☐ Hearing problems
☐ Loss of balance
☐ Pain at night
☐ Vertigo/Dizziness
☐ Visual problems
☐ Weakness
☐ Other: _______________________________________

Please mark your pain today with an “X” on this scale

No Pain

Worst possible pain

Please indicate below where you are experiencing symptoms (use legend)

**Please note that separate body parts may need separate evaluations before treatment can be added.

When did symptoms begin? (this episode): ___________________________

What caused symptoms? (if known): __________________________________

What makes the symptoms:

Better? _____________________________________

Worse? _____________________________________
MEDICAL HISTORY

Check all that apply

☐ Anxiety  ☐ GERD/acid reflux  ☐ Muscular Dystrophy
☐ Arthritis  ☐ Head injury  ☐ Osteoporosis
☐ Broken bones/Fractures  ☐ Heart problems  ☐ Parkinson's disease
☐ Cancer  ☐ High blood pressure  ☐ Seizure
☐ Circulatory problems  ☐ Jaw issues  ☐ Sinus
☐ Depression  ☐ Kidney problems  ☐ Stroke
☐ Diabetes  ☐ Liver problems  ☐ Varicose veins
☐ Dizziness  ☐ Lung problems/Asthma  ☐ Vestibular
☐ Eye problems  ☐ Multiple Sclerosis  ☐ Other (e.g. major illness/recurrent issues):

Allergies? (check all that apply)

☐ None  ☐ Latex  ☐ Adhesive  ☐ Other ____________________________________________________________________________

Major injury history (childhood through adulthood): __________________________________________________________________________

Surgery history (any, including c-section, dental, plastic etc.): ___________________________________________________________________

LIFESTYLE FACTORS

Exercise: (check all that apply)

☐ Stepmill; Elliptical; Stationary bike  ☐ Running  ☐ Weight training  ☐ Walking  ☐ Pilates  ☐ Yoga  ☐ Swimming

How often? Hours/Week:_________ Days/Week:_________

Activities for recreation: (check all that apply)

☐ Hiking  ☐ Soccer  ☐ Basketball  ☐ Snow sports  ☐ Racquet sports

How often? Hours/Week:_________ Days/Week:_________

Smoking:  ☐ Yes  ☐ No  If yes, how many packs/day? __________

Alcohol consumption:  ☐ Yes  ☐ No  If yes, how often? __________

During the past month, have you often been bothered by:

-feeling down, depressed or hopeless?  ☐ Yes  ☐ No
-little interest or pleasure in doing things?  ☐ Yes  ☐ No

Stress Levels
Please mark with an “X” on this scale

________________________________________________________________________

SIGNATURES

Signature (age 18 or older): ___________________________ Date: ____________

Parent/Guardian Name: ___________________________ Signature: ___________________________

(If under 18 years, parent or guardian signature required)

Date: ____________