



## PHYSICAL THERAPY

### MEDICAL HISTORY

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Thank you for answering the following questions so that we can administer your treatment safely and effectively.**

Date of birth: \_\_\_\_\_

For what problem have you been referred to physical therapy?

Who referred you to our clinic?

How and when did injury occur?

Date of last hospitalization: \_\_\_\_\_

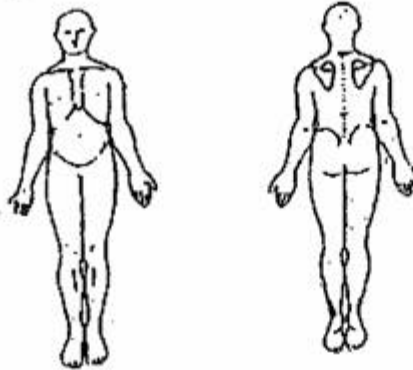
Date of surgery related to this problem: \_\_\_\_\_

List any other surgeries you have had in the past 5 years:

Date of last admission to nursing home: \_\_\_\_\_

How is your current injury restricting your daily activities? (i.e. walking, dressing, driving, sports, activities, etc.)

Where is your pain? Please mark on the drawings below the areas where you feel pain.



Please rate your pain on a scale of 0-10:

NO PAIN    1    2    3    4    5    6    7    8    9    10

*Please fill out page 2.*

**DO YOU HAVE ANY OF THE FOLLOWING? (circle yes or no)**

CARDIAC PACEMAKER	yes	no
METAL IMPLANTS OF ANY KIND	yes	no
DIABETES	yes	no
HEART PROBLEMS	yes	no
CONVULSIONS OR SEIZURES	yes	no
HIGH BLOOD PRESSURE	yes	no
OSTEOPOROSIS	yes	no
RHEUMATOID ARTHRITIS	yes	no
Are you currently being treated by a Chiropractor?	yes	no
Are you allergic to any drugs, adhesive tape or disinfectant substances?	yes	no

List any medications you are currently taking:

List any other problems:

Have you had any prior PT for any problem during the past calendar year in an outpatient setting?

If yes, list dates and describe the treatment you received:

Would it be ok to contact your home phone if needed?

Leave a message?

To properly insure we submit to the correct insurance company we will need the following information.

**How are we billing for your services today? Please circle one of the following:**

**Medicare Primary**

**Commercial Ins**

**Workman's Comp**

**Auto Insurance**

**Cash**

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*Signature of patient or representative:*

*Date:*