This information is strictly confidential. Your answers will help us determine if physical therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate as possible. If you do not understand a question, please ask your therapist for assistance.

MEDICAL HISTORY HEALTH FORM

If you do not understand a question, please ask your therapist for assistance.

Your Name: _____ **Date**: _____**DOB**:_____

Describe the problem you are seeing the physical therapist for:_____

_____

When did you first notice symptoms? _____

_____

Please rate your pain on a 0-10 scale (1 is very mild pain, 10 is the worst imaginable pain):

1 2 3 4 5 6 7 8 9 10

Please circle/describe your symptoms:

Constant (24 hours/day)	Burning	Numbness
Intermittent (comes and goes)	Pins and Needles	Throbbing
Knife-like/ Sharp	Dull/aching	
Other: _____		

Have you seen a physical therapist or had other treatments for this within the past year? _____

_____

Referring Physician: Date of Next Follow-up: _____

Leisure Activities: _____

Have you ever been diagnosed with any of the following? If "Yes", please explain in the space provided.

Disease Processes:

Cancer	No	Yes_____
Diabetes Mellitus	No	Yes_____
High Blood Pressure	No	Yes_____
Arthritis	No	Yes_____
Osteoporosis	No	Yes_____
Seizures	No	Yes_____
Coronary Artery Disease	No	Yes_____
Heart or Vascular Diseases	No	Yes_____
Neurological diseases	No	Yes_____

Embody
ORTHOPEDIC & SPORTS PHYSICAL THERAPY

Current Health/Medical Conditions:

Do you have chest pain (angina)?	No	Yes _____
Do you have a Pacemaker or electrical implant?	No	Yes _____
Do you have breathing problems?	No	Yes _____
Do you have frequent headaches/migraines?	No	Yes _____
Unexplained nausea/vomiting?	No	Yes _____
Unexplained fever, night sweats?	No	Yes _____
Does pain wake you from sleep?	No	Yes _____
Changes in bowel and bladder function?	No	Yes _____
Dizziness/vertigo?	No	Yes _____
Numbness and tingling?	No	Yes _____
Urinary tract infection (less than 1 month ago)?	No	Yes _____
Osteoporosis	No	Yes _____
Are you currently pregnant?	No	Yes _____
How many weeks?_____		
Menstrual irregularities?	No	Yes _____
Taking Birth Control	No	Yes _____
Difficulty swallowing?	No	Yes _____
Weight Loss/Gain?	No	Yes _____
Changes in appetite?	No	Yes _____
Fatigue?	No	Yes _____
Weakness?	No	Yes _____
Fever/chills/sweats?	No	Yes _____
Depression?	No	Yes _____

Social History:

Tabacco use?	No	Yes _____
Have you recently suffered trauma from a fall, car Accident, sports, etc?	No	Yes _____ Date: _____
Difficulty hearing?	No	Yes _____
Speech problems?	No	Yes _____
Vision problems?	No	Yes _____

Please describe any <u>injuries and/or surgeries</u> for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:_____

_____

Please list any <u>Non-prescription and Prescription</u> medications that you are currently taking (including pills, injections or skin patches):

_____

What are your goals for physical therapy?_____