Medical History

Patient Name: ______________________

Date condition began ________________________ Is this a work related injury? ☐ Yes ☐ No

Date of Surgery (if applicable) ________________________

Date of next doctor appointment for this condition ________________________

Rate your symptom intensity in the past 5 days: Symptoms at worst = _______ out of 10

(0 is no pain or symptoms and 10 is worst possible pain or symptoms) Symptoms at best = _______ out of 10

Have you received therapy in the past 12 months? ☐ Yes ☐ No

If yes, for what condition? ____

Do you have a history of:

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
☐	☐	Chest Pain	☐	☐	Closed Head Injury	☐	☐	Osteoporosis	☐	☐	Bipolar Disorder
☐	☐	Irregular Heart Rhythm	☐	☐	Concussions	☐	☐	Osteopenia	☐	☐	Depression
☐	☐	Congestive Heart Failure	☐	☐	Migraine headaches	☐	☐	Hepatitis B	☐	☐	Anxiety
☐	☐	DVT/Blood Clot	☐	☐	Gout	☐	☐	Hepatitis C	☐	☐	Urinary Incontinence
☐	☐	Heart Disease	☐	☐	Osteoarthritis	☐	☐	HIV/AIDS	☐	☐	Frequent UTI
☐	☐	High Cholesterol	☐	☐	Rheumatoid Arthritis	☐	☐	MRSA	☐	☐	Visual Disorder
☐	☐	High Blood Pressure	☐	☐	Psoriatic Arthritis	☐	☐	Tuberculosis	☐	☐	Diabetes Type I
☐	☐	MI/Heart Attack	☐	☐	Carpal Tunnel Syndrome	☐	☐	Hypothyroidism	☐	☐	Diabetes type II
☐	☐	Shortness of breath	☐	☐	Chronic Back Pain	☐	☐	Cancer (type)	☐	☐	Hiatal Hernia
☐	☐	Peripheral Vascular Dis	☐	☐	Chronic Neck Pain	☐	☐	Lymphedema	☐	☐	Colitis/IBS
☐	☐	CVA (Stroke)	☐	☐	Degenerative Disc Disease	☐	☐	Cellulitis	☐	☐	Stomach Disorder
☐	☐	Blood Clotting Disorder	☐	☐	Scoliosis	☐	☐	Mutiple Sclerosis			(list below)
☐	☐	Asthma	☐	☐	Auto-Immune Disorder	☐	☐	Seizure Disorder	☐	☐	Other Allergies (list)
☐	☐	COPD/Lung Disease	☐	☐	Fibromyagia	☐	☐	Other Neurologic Condition (list below)			
☐	☐	**Pace Maker**	☐	☐	**Latex Allergy**	☐	☐	**Pregnant - if yes, how many weeks? ________**			

Other conditions not listed:____

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Past Surgical History:

Yes	No	Surgery	Yes	No	Surgery	Yes	No	Surgery
☐	☐	Open Heart surgery	☐	☐	Rotator Cuff Repair	☐	☐	Total Hip Replacement
☐	☐	Heart Procedure	☐	☐	Shoulder Surgery (list)	☐	☐	Total Knee Replacement
☐	☐	Lung Surgery	☐	☐	Ligament Repair (list)	☐	☐	Total Shoulder Replacement
☐	☐	Low Back Surgery	☐	☐	Knee Surgery (list)	☐	☐	Other Joint Replacement
☐	☐	Neck Surgery	☐	☐	Amputation	☐	☐	Fractures requiring surgical repair
☐	☐	Brain Surgery	☐	☐	Major Abdominal Surgery	☐	☐	Other Major Surgery (list)

Details about Surgery: ____

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Please list your current medications: IF YOU HAVE A LIST WE CAN COPY IT.:

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Diagnostic Tests for current condition	
Test	**Results**
Xray	
MRI	
Bone Density Scan	
CT Scan	
EMG	
Ultrasound	
Other:	

Type of home:

- ☐ Single Level Home
- ☐ 2 Level Home
- ☐ Ground Floor Apartment
- ☐ Upper Level Apartment
- ☐ Assisted Living Facility
- ☐ Skilled Nursing Facility
- ☐ Other: ____________

Do you have anyone at home to help you if needed? ☐ Yes ☐ No ____________

How many times have you fallen in the past 12 months? ____________

Have any falls resulted in injury? ☐ Yes ☐ No ____________

Do you currently smoke? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Do you drink alcohol? ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Never

Occupation: ____________

Work Status: ☐ Employed Full Time ☐ Employed Part Time ☐ Not employed ☐ Full time student ☐ Retired ☐ Permanently Disabled ☐ Part time student

Current Ability to work: ☐ Able to perform all duties ☐ No formal restrictions ☐ Restricted duties/schedule ☐ Off work ☐ Temporary Disability

Please outline restrictions: ____________

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Normal work duties:

- ☐ Sitting for extended periods
- ☐ Standing for extended periods
- ☐ Repetitive Bending
- ☐ Repetitive Lifting
- ☐ Lifting moderate weights
- ☐ Lifting Heavy Weights
- ☐ Operating Heavy Equipment
- ☐ Driving
- ☐ Typing/computer operation
- ☐ Walking

Which of these duties are you NOT able to perform normally? ____________

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