# MEDICAL HISTORY

Name: _____

*OFFICE USE ONLY*
PATIENT ACCT. #: _____

Do you have any previous history of:

High Blood Pressure…… Yes No
Heart Condition……..Yes No
Stroke ……Yes No
Diabetes ……..Yes No

Pace Maker…….Yes No
Seizures……. Yes No
Cancer ……Yes No (If yes, please specify)
_____

**Other** (Specify) _____

Have you been admitted to the hospital in the past five years? Yes No
If so for what condition? _____
Which hospital? _____
Is this condition the reason you were referred to physical therapy? Yes No

Have you received physical therapy treatments during the past year? Yes No
If so, was it helpful? Yes No
Why or Why Not? _____
_____

List all medications you are currently taking _____, _____
_____, _____, _____, _____

Do you have any other medical conditions we should be aware of? _____
_____

How often do you exercise? Never 1-2/week 3-4/week 5-7/week

What kind of exercise/activities? _____
_____

| | **Very little…….Moderate……Very Much** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| How much is your current injury affecting your ability to work? | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How much is your current injury affecting your extra-curricular Activities? | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| How much is your current injury affecting your home life? | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What is your **average** level of pain with this injury? | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| What is your **maximum** level of pain with this injury? | 0 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

What would you most like to accomplish through physical therapy treatments? _____
_____
_____
_____

Patient Signature: _____ Date: _____