Medical History Form

Patient Name:	**Today's Date:**	
Referring Physician:	**Date of Birth:**	**Age:**
Primary Care Physician:	**Date of Injury or Onset:**	
Date of Next Physician Appointment:		

Reason for Therapy:

Cause of Injury or Onset: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain:**

Have you been hospitalized for the present condition? ☐ Yes ☐ No **If Yes, date:**

Did you have surgery for this condition? ☐ Yes ☐ No **If Yes, date:**
If Yes, surgery type:

Are you currently receiving any other care for the condition mentioned above? ☐Yes ☐No
If Yes, please describe:

Have you ever received therapy in the past for the condition mentioned above? ☐Yes ☐ No **If Yes, date:**
Describe previous treatment:

Previous Treatment: ☐Successful ☐Unsuccessful

Have you fallen in the last year? ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
Do you feel unsteady when standing or walking? ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

What are your personal goals/outcomes you hope to achieve from therapy?

Describe your general health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Do you smoke or use tobacco?** ☐ Yes ☐ No

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

☐ Allergies ☐ Latex ☐ Other	☐ Dizziness	☐ Kidney Problems
☐ Anemia	☐ Epilepsy or Seizure Disorder	☐ Metal Implants
☐ Anxiety or Panic Disorders	☐ Fainting	☐ MRSA
☐ Arthritis ☐ OA ☐ RA	☐ Fatigue or Weakness	☐ Multiple Sclerosis
☐ Asthma	☐ Fever or Chills	☐ Nausea / Vomiting
☐ Use of Blood Thinners	☐ Fractures	☐ Osteoporosis
☐ Bowel or Bladder Disorder	☐ Headaches	☐ Pacemaker
☐ Bleeding Disorder	☐ Head Injury or Concussion	☐ Parkinson's Disease
☐ Cancer	☐ Hearing Impairment	☐ Peripheral Vascular Disease
☐ Chronic Cough	☐ Heart Disease or Heart Attack	☐ Respiratory or Breathing Problems
☐ COPD	☐ Hepatitis ☐ A ☐ B ☐ C	☐ Ringing in Ears
☐ Congestive Heart Failure	☐ Hernia	☐ Sexual Dysfunction
☐ Currently Pregnant	☐ Blood Pressure ☐ High ☐ Low	☐ Skin Abnormalities
☐ Deep Vein Thrombosis (DVT)	☐ HIV or AIDS	☐ Stroke or TIA
☐ Depression	☐ Hypoglycemia	☐ Thyroid Problems
☐ Diabetes ☐ Type I ☐ Type II	☐ Hypersensitivity to Hot or Cold	☐ Tuberculosis

List any other medical problems and explain:

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Medication List

Name of Medication	Dosage	Frequency	
☐ Check Box if Medication List provided separately.			
1.			☐ Injection ☐ Oral ☐ Topical ☐ Other
2.			☐ Injection ☐ Oral ☐ Topical ☐ Other
3.			☐ Injection ☐ Oral ☐ Topical ☐ Other
4.			☐ Injection ☐ Oral ☐ Topical ☐ Other
5.			☐ Injection ☐ Oral ☐ Topical ☐ Other
6.			☐ Injection ☐ Oral ☐ Topical ☐ Other
7.			☐ Injection ☐ Oral ☐ Topical ☐ Other
8.			☐ Injection ☐ Oral ☐ Topical ☐ Other
9.			☐ Injection ☐ Oral ☐ Topical ☐ Other
10.			☐ Injection ☐ Oral ☐ Topical ☐ Other
11.			☐ Injection ☐ Oral ☐ Topical ☐ Other
12.			☐ Injection ☐ Oral ☐ Topical ☐ Other

Over the Counter Medications (check all that apply): ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

Pain Scale

Rate the severity of your pain by circling a box on the following scale.

No Pain — Worst Pain

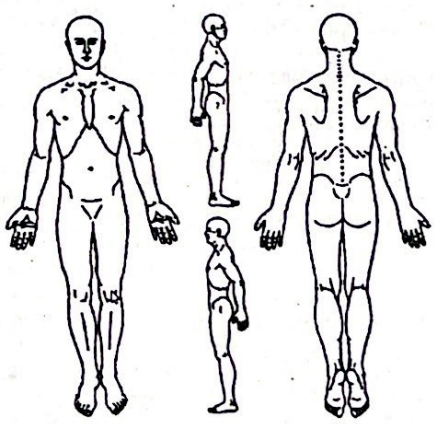
1	2	3	4	5	6	7	8	9	10

On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.

KEY:

A = Aching B = Burning N = Numbness

P = Tingling S = Stabbing O = Other



Signature of Patient:

Printed Name of Patient: **Date:**