



MEDICAL HISTORY FORM

Name: _____ Occupation: _____

Present Illness or Injury:

What is your current problem? _____

How did the present injury occur? _____

Date of the injury? (Please be as accurate as possible): _____

Did you undergo surgery? Yes ___ No ___ (If yes, when?): _____

Have you had any testing? No ___ Yes ___/What type?:CT scan ___ MRI ___ Xrays___ EMG ___

Have you had any previous therapy for this problem?: No ___ Yes ___ When? _____

If you have any pain or discomfort, please describe below:

Location of pain _____ Intensity of pain (0-10, scale, 0= lowest): _____

(Circle one): Constant or Intermittent. What aggravates it? _____

What helps it? _____

What can't you do with this condition? _____

List other symptoms associated with this condition:(Ex: weakness, numbness, less movement, etc)

MEDICAL HISTORY: * please checkmark if you have any of the following:

- | | | |
|---|---|---|
| <input type="checkbox"/> diabetes | <input type="checkbox"/> history of cancer | <input type="checkbox"/> arthritis problems |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> respiratory illness | <input type="checkbox"/> joint problems |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney illness | <input type="checkbox"/> acute infections |
| <input type="checkbox"/> hemophilia | <input type="checkbox"/> previous head trauma | <input type="checkbox"/> heart attack(s) |
| <input type="checkbox"/> previous back problems | <input type="checkbox"/> spinal injuries | <input type="checkbox"/> stroke (s) (CVA) ___ |
| <input type="checkbox"/> shoulder dislocation | <input type="checkbox"/> special diet restrictions | <input type="checkbox"/> hernia |
| <input type="checkbox"/> metal implant | <input type="checkbox"/> currently pregnant | <input type="checkbox"/> pacemaker |
| <input type="checkbox"/> allergies | <input type="checkbox"/> surgery to head, neck or spine | |

List your current medications: _____

List any hospitalizations or surgeries in the past 5 years: _____

Have you had any previous physical, occupational or speech therapy in the last year? _____

If so, when and where: _____

Have you had any home health services in the last year? _____ If so, when and where: _____

What are your expectations or goals while you are in therapy? _____

I have read and filled out this questionnaire to the best of my knowledge.

Patient Signature: _____ Date: _____

Initiated: 3/25/04

Revised: 2/24/09