THERAPY PARTNERS OF NORTH TEXAS MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? YES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

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

- ☐ ANEMIA
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ CARDIOVASCULAR PROBLEMS
- ☐ HOLTER MONITOR - currently wearing?
  - ☐ PACEMAKER
  - ☐ HIGH BLOOD PRESSURE ☐ controlled ☐ uncontrolled
- ☐ LOW BLOOD PRESSURE
- ☐ CURRENTLY PREGNANT
- ☐ DIABETES ☐controlled ☐uncontrolled
- ☐ DEPRESSION
- ☐ DIZZINESS/FAINTING
- ☐ FRACTURES
- ☐ HEADACHES
- ☐ HEPATITIS/HIV
- ☐ KIDNEY PROBLEMS
- ☐ MRSA (Methicillin Resistant Staphylococcus Aureus)
- ☐ OSTEOPOROSIS
- ☐ RESPIRATORY PROBLEMS
  - ☐ ASTHMA ☐ controlled ☐ uncontrolled
  - ☐ COPD ☐ controlled ☐ uncontrolled
  - ☐ Other
- ☐ SEIZURES ☐ controlled ☐ uncontrolled
- ☐ THYROID PROBLEMS
- ☐ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

 Revised 4.16.15 KB