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.

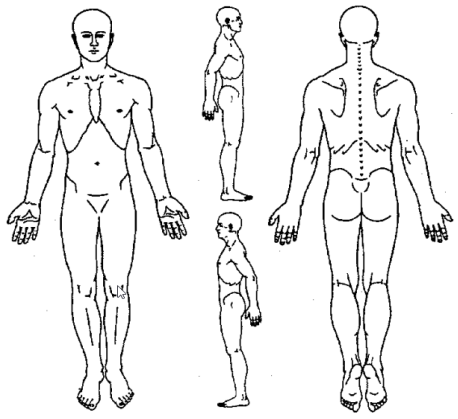
No Pain — Worst Pain

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:	**DOB:**
Printed Name of Patient:	**Date:**