# Healing Integrations

## Patient Medical History

**Patient Name:** _____ **Age:** _____

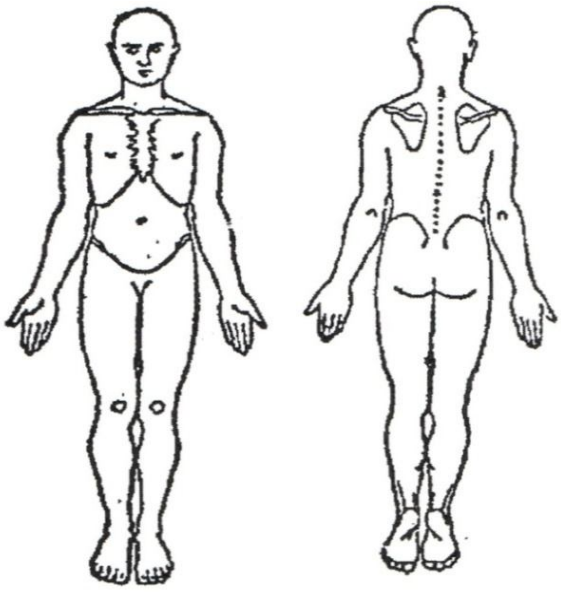
**Type of Injury / Condition:** _____

**Onset / Injury Date:** _____

**Type(s) of Surgery:** _____ **Date:** _____

**Describe previous treatment for this condition:** _____

**Have you had any imaging performed?**
□ X-RAY □ MRI □ CT Scan □ Doppler □ Ultrasound



**Have you recently noticed or suffer from any of the following?**
□ Weight Loss / Gain □ Weakness □ Numbness / Tingling
□ Depression □ Grief □ Headaches □ Insomnia □ Fatigue
□ Fever / Chills / Sweats □ Pain at Night □ Pregnant / IUD
□ Change in Vision or Hearing □ Cramps in Legs When Walking

**Do you have now or have you ever had any of the following?**
□ Surgeries □ Loss of Consciousness □ Fractures □ Diabetes
□ Sprains / Strains □ Cancer □ Blood Pressure Problems
□ Heart Problems □ Motor Vehicle Accident □ Lung Disease
□ Circulation Problems / Clots □ Asthma / Breathing Problems
□ Easy Bruising / Bleeding □ Leg / Ankle Swelling □ Fainting
□ Urinary Problems / Infections □ Indigestion / Heartburn
□ Allergies / Skin Sensitivity

□ **Any previous injury that may affect current care:** _____

**Explain and give approximate dates for any items indicated above:** _____
_____

**Are you currently taking medications? Yes / No. Name or Type of Medication(s):** _____
_____

**What type(s) of Pain**: Sharp / Burning / Aching / Tingling / Numbness / Other: _____

**Rate your Pain (1 = minimal, 10 = severe)**
**At its <u>worst</u>:** 1 2 3 4 5 6 7 8 9 10 **<u>Currently</u>:** 1 2 3 4 5 6 7 8 9 10

**What goals do you want to achieve with physical therapy?** _____
_____

**Is there anything else you would like to include or ask your physical therapist?** _____
_____

**Signature of Parent or Legal Guardian:** _____ **Date:** _____