***FLEX*** **Physical Therapy**

***#480-694-5013***

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**Patient Medical History**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Onset date of illness:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is injury related to a motor vehicle accident? Yes \_\_\_\_\_ No \_\_\_\_\_

Primary Care Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have had surgery for this condition? Yes\_\_\_\_ No \_\_\_\_ Type of surgery:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently taking any prescription or non-prescriptions? Yes\_\_\_\_ No \_\_\_\_

Ant-inflammatory \_\_\_\_\_\_\_\_ List of medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Muscle Relaxers \_\_\_\_\_\_\_\_ (include dose and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pain Medication \_\_\_\_\_\_\_\_ frequency) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if you have had any of the following medical/rehabilitative service for this condition:**

* MRI/CT Scan
* EMG/NCV
* X-Ray
* Other Diagnostic Test

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Chiropractor
* Emergency Room Care
* General Practitioner
* Massage Therapy
* Neurologist
* Occupation Medicine Doctor
* Occupational Therapy
* Orthopedist
* Physical Therapy
* Podiatrist
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check if you have a history of any of the following:**

* Anemia
* Asthma/Bronchitis/Emphysema
* Blood Clot/Emboli
* Cancer or Chemo/Radiation
* Diabetes
* Emotional/Psychological Issues
* Epilepsy/Seizures
* Heart Attack or Heart Surgery
* Heart Disease or Angina
* High Blood Pressure
* Infectious Disease
* Pacemaker
* Shortness of breath/chest pain
* Sleeping Problems/Disorders
* Stroke/TIA
* Thyroid Trouble/Goiter
* Tuberculosis
* Allergies
* Bowel or Bladder Problems
* Dizziness or Fainting
* Hernia
* Numbness or Tingling
* Severe or Frequent Headaches
* Varicose Veins
* Vision or Hearing Difficulties
* Weakness
* Weight Loss/Energy Loss
* Any Pins or Metal Implants
* Arthritis/Swollen Joints/Gout
* Back Injury/Surgery
* Elbow/Hand Injury/Surgery
* Joint Replacement
* Knee Injury/Surgery
* Leg/Ankle/Foot Injury/Surgery
* Neck Injury/Surgery
* Osteoporosis
* Shoulder Injury/Surgery

Have you had 2 or more falls in the last year or any fall with an injury in the last year? Yes\_\_\_\_ No\_\_\_\_\_

Are you aware of your diagnosis? Yes \_\_\_\_\_ No \_\_\_\_\_ Are you pregnant? Yes\_\_\_\_ No\_\_\_\_

What are your goals in this program? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have reviewed this medical history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature