# Medical History Form

Patient Name: _____ Date: _____ Age: _____

Chief Complaint: _____

Please check below if you have or ever had any of the following:

| | | |
|---|---|---|
| _____ Diabetes Mellitus | _____ Stroke / TIA | _____ Pacemaker |
| _____ High Blood Pressure | _____ Cancer or Radiation | _____ Arthritis |
| _____ Asthma / Emphysema | _____ Cardiac Problems | _____ Pain in Joints/Swelling |
| _____ Infectious Disease | _____ Sinus Problems | _____ Thyroid Problems |
| _____ Epilepsy / Seizures | _____ Osteoporosis | _____ Fractures |
| _____ Dizziness or Faintness | _____ Chronic Headaches | _____ Paralysis |
| _____ Vision / Hearing Difficulties | _____ Falls | _____ Currently Pregnant |

Are you aware of your diagnosis and prognosis? ____ Yes ____ No

List any surgeries, including dates: _____

_____

List any medications you are presently on: _____

_____

Are you allergic to any medication? ____ Yes ____ No If so, please list: _____

Have you had any Diagnostic or Rehabilitative Services for this Injury? MRI ____ Xrays____

Other: _____ Can you bring a copy with you ____ Yes ____ No

Rate Your pain: 1 2 3 4 5 6 7 8 9 10

No Pain Severe Pain

Height: _____ Weight: _____ BMI: _____

What position or activity worsens your pain?

_____

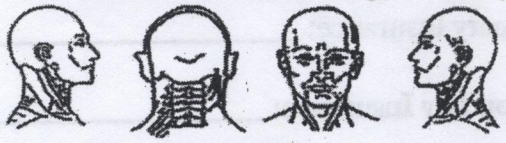
What position or activity eases your pain?

_____

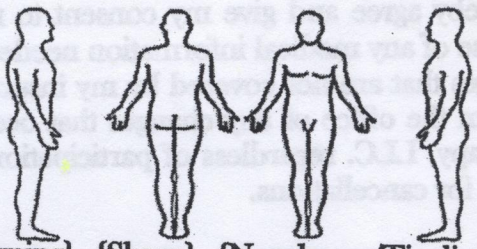
Is your sleep disturbed? ____ Yes ____ No

Circle the following regarding your condition:
{Improving} {Worsening} {Staying the Same}

If you have pain, where is it located?
(Mark with an "X" on the diagram below)



Right Side Back Front Left Side



Circle the following to describe your pain: {Ache} {Pressure} {Burning} {Sharp} {Numbness/Tingling} {Throbbing} {Shooting} {Constant} {Occasional} {Morning Pain} {Evening Pain} {Activity Related}

What are you unable to do now, what is difficult? _____

What do you want to be able to do? _____

What are your goals for therapy? _____