Past Medical History Form

Today’s Date: ____________________ Referring Physician: ____________________

1. Please check if you have ever had:
   [ ] High Blood Pressure          [ ] Infectious disease (Tuberculosis, hepatitis, HIV)          [ ] Kidney problems
   [ ] Seizure/Epilepsy              [ ] Mental illness (Depression, Bipolar, etc.)          [ ] Repeated infections
   [ ] Pacemaker / Metal implant     [ ] Developmental or growth problems               [ ] Asthma, Lung/Breathing problem
   [ ] Latex allergy                  [ ] Thyroid problems                               [ ] Low blood sugar/hypoglycemia
   [ ] Heart problems                [ ] Broken bone/fracture                             [ ] Diabetes/High blood sugar
   [ ] Skin diseases                 [ ] Circulation/vascular problems                   [ ] Blood disorders (Anemia)
   [ ] Arthritis/gout                [ ] Cancer, including Melanoma                      [ ] Ulcer/stomach problems
   [ ] Osteoporosis                  [ ] Neurological (Stroke, Parkinson, Multiple Sclerosis, etc)
   [ ] Head injury                    
   [ ] Other: ________________________

   Please explain any box checked above: __________________________________________

2. Within the past 6 months, have you had any of the following symptoms? (Check all that apply)
   [ ] Fall or Loss of Balance, Dizziness or blackouts, Weakness in legs
   [ ] Pain at night, Difficulty sleeping
   [ ] Urinary problems or incontinence (can’t hold your water)
   [ ] Hearing loss
   [ ] Vision problems
   [ ] Nausea/vomiting
   [ ] Coordination problems
   [ ] Chest pain
   [ ] Other: ________________________

   Other: ________________________

3. Have you had any testing, X-rays, MRI, blood work, etc.)? If so, what were the results?
   ________________________________

   ________________________________

4. Have you had any illness within the last three weeks?(cold, flu, fever, bladder, kidney infections)
   ________________________________

5. What is your occupation? or retired from? ________________________________

6. Describe the problem for which you are seeking physical therapy
   ________________________________

7. When did the problem begin (Dates): ________________________________

8. Have you ever had the problem before?  [ ] No  [ ] Yes  Explain: ________________________________

9. Did the injury happen at work or in a car accident?  [ ] No  [ ] Yes  (Date of accident)__________________________

10. Are you out of work due to your injury?  [ ] No  [ ] Yes  Give last day worked.__________________________

11. Have you had physical therapy or any other treatment for this condition?  [ ] No  [ ] Yes  What type, where, and with whom?__________________________

12. Do you understand the attendance policy and realize that your lack of attendance, frequent Cancellations and No Shows for appointments, and lack of progress in physical therapy will result in your discharge from physical therapy. We will notify your doctor and insurance company of your discharge due to your lack of attendance, participation, and progress in physical therapy.  [ ] No  [ ] Yes

13. How do you learn best?  Reading, Listening, Demonstration, Other: ________________________________
Please rate your overall pain on the scale below:  

\[0 = \text{no pain}; \quad 10 = \text{worst pain possible, (crying)}\]

*ATTENTION PATIENT*  SIGN THIS FORM when your questions have been answered to your satisfaction.

*Patient Signature:_________________________ Date:_________________________

Therapist Signature:_________________________ Date:_________________________