MEDICAL HISTORY FORM

Patient name _____
Height _____ Weight _____ Date of injury _____

Diagnosis as stated to you by your physician _____
How did injury/exacerbation occur?
_____
_____
Hospitalization for present condition? Y N Date _____
Surgery for present condition? Y N Date _____
Type of surgery_____
Any falls in past year? Y N If yes, how many? _____
Prior treatment for this condition? Y N Date _____
Description of prior treatment _____

Any prior diagnostic testing? Y N
Xray MRI EMG CT scan Myelogram Other _____

Check if you have ever been treated for any of the following conditions:
__ Acquired respiratory distress syndrome
__ Allergies
__ Angina
__ Anxiety or panic disorders
__ Arthritis (RA, OA)
__ Asthma
__ Back injury
__ Bleeding disorders
__ Bowel/Bladder abnormalities
__ Cancer
__ Chronic obstructive pulmonary disease (COPD)
__ Congestive heart failure (CHF)
__ Degenerative disc disease (spinal stenosis, chronic back pain, etc)
__ Depression
__ Diabetes
__ Dizziness or fainting spells
__ Emphysema
__ Epilepsy or seizure disorder
__ Fracture
__ Hearing impairment
__ Headaches
__ Heart attack
__ Hepatitis A, B or C
__ Hernia
__ High blood pressure
__ Hypoglycemia
__ Immunosuppressant condition or medication
__ Kidney problems

__ Liver/Gallbladder problems
__ Metal implants
__ Multiple sclerosis
__ Nausea/Vomiting
__ Osteoporosis/osteopenia
__ Pacemaker
__ Parkinson's disease
__ Peripheral vascular disease
__ Pregnancy
__ Ringing in ears
__ Sexual dysfunction
__ Skin abnormalities
__ Smoking
__ Special diet guidelines
__ Stroke or TIA
__ Tuberculosis
__ Upper gastrointestinal disease (ulcer, hernia, reflux)
__ Visual impairment

Medications _____

Symptoms: Pain Numbness Tingling Weakness Instability Stiffness
Limited range of motion Other _____
Aggravating factors _____
Easing factors _____
Symptoms worse: in morning/during day/at night/constant/with activity/at rest
Pain level 0-10 (0=no pain, 10=emergency room level)
Current level _____ At best _____ At worst _____

Any other pertinent medical history
_____
_____

Goal for therapy at this time _____

_____
Signature of Patient or Guardian (if patient is a minor) Date

_____
Signature of Clinician Date