



## PATIENT MEDICAL HISTORY

Patient Name: \_\_\_\_\_ Patient DOB: \_\_\_\_\_

Please check all that apply to you:

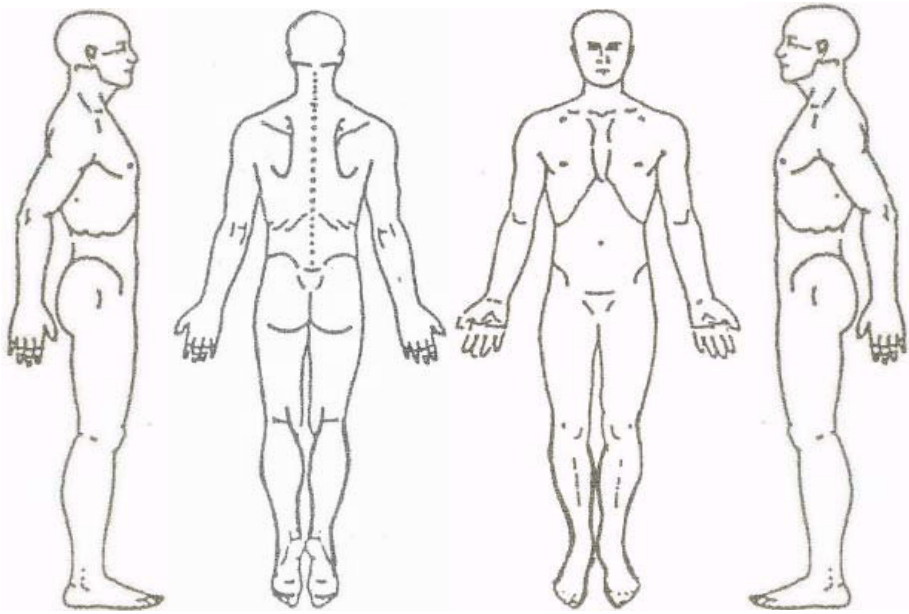
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where?	_____	
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Where?	_____	
Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint / Muscle Pain		
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neck	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shoulder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Elbow	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma / Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Wrist / Hand	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Upper Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mid Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Back	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	SI Joint	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hip	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest pain at rest?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Knee	<input type="checkbox"/> Yes	<input type="checkbox"/> No
- with exercise?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ankle / Foot	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other:	_____	
Where?	_____		Surgeries	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When?	_____		List: _____		
Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____		
List: _____			_____		
_____			Speech,	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____			swallowing, or		
			thinking problems		

If checked, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If there is a condition not indicated above, please include in the "Other" section and explain:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prior physical therapy (if yes, please explain): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Medication(s): \_\_\_\_\_  
 \_\_\_\_\_



Please mark the diagram with the following symbols to describe where your pain is.

<b>↑ or ↓</b>	<b>KEY</b>
<b>XXX</b>	Radiating Pain
<b>ZZZ</b>	Spasm
<b>/////</b>	Tenderness
<b>0000</b>	Numbness/Tingling
	Ache/Pain

Please rate (circle) your pain on a 0-10 scale (0 = no pain; 10 = excruciating pain)

At this time: 0 1 2 3 4 5 6 7 8 9 10      Worst pain: 0 1 2 3 4 5 6 7 8 9 10  
 Least amount of pain: 0 1 2 3 4 5 6 7 8 9 10

How would you describe your pain:

- Shooting    Prick    Throb    Ache    Pull    Dull    Burn    Sharp
- Other \_\_\_\_\_

As it relates to your current problem, are you unable to or have difficulty with performing any of the following activities due to pain and / or weakness? Check all that apply:

- Getting in/out of a car       Getting in/out of bed       Shaving       Writing       Sleeping
- Getting in/out of a chair       Brushing teeth       Cooking       Dressing       Eating
- Personal hygiene activities       Work Activities       Shopping       Sitting       Driving
- Walking up/down stairs       Bathing/Shower       Standing       Laundry       Vacuuming
- Getting in/out of shower       Walking       Lifting       Cleaning

Other: \_\_\_\_\_

What relieves pain? (Please check all that apply)

- Medication \_\_\_\_\_
- Massage    Relaxation techniques    Rest    Heat    Cold    Sleep    Repositioning
- Exercise \_\_\_\_\_       Other \_\_\_\_\_

What causes pain to increase? \_\_\_\_\_

Patient Name (Printed): \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_