MEDICAL HISTORY

Name _____ DOB ____/____/____ Occupation _____

***Do you now or have you ever had any of the following**: (check all that apply)*

☐ Diabetes	☐ Open wounds	☐ CVA / Stroke
☐ Arthritis	☐ Current infection(s)	☐ Previous fractures
☐ High blood pressure	☐ Hypersensitivity to Heat/Cold	☐ Osteoporosis
☐ Heart disease	☐ Allergies	☐ Anxiety
☐ Pacemaker	☐ Females-Presently pregnant	☐ Substance abuse
☐ Vascular disease	☐ Seizures	☐ Previous surgeries
☐ Headaches	☐ Metal in body	☐ Incontinence
☐ Kidney problems	☐ Cancer/Tumor	☐ Other
☐ Fever/Night sweats	☐ Thyroid problems	☐ NONE OF THE ABOVE

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.IF A QUESTION DOES NOT APPLY LEAVE IT BLANK.

THE THERAPIST WILL DISCUSS ANY QUESTIONS WITH YOU.

1) Date symptoms / injury began _____

2) Where did symptoms / injury occur **Home** _____ **Work** _____ **Car Accident** _____ **Other**____ **Unknown**_____

3) How did symptoms / injury occur _____

4) Have you had **Injections**_____ **X-rays** _____ **MRI**_____ **EMG**_____ **Other** _____

5) Have you been hospitalized for this problem? ☐ NO ☐ YES, How long? _____

6) Did you have surgery? ☐ NO ☐ YES, What type? _____

7) Are you taking **Any** medication? ☐ NO ☐ YES, What type?

_____

8) What are your personal goals for physical therapy? _____

9) Have you had physical therapy this year? _____ Yes _____ No

If so what kind of therapy? **Home** _____ **Out Patient** _____ **Out Patient Hospital** _____ **In Patient**_____

10) Do you Use Tobacco _____ Consume Alcohol _____

11) Overall, how do you personally rate your health? ☐EXCELLENT ☐ VERY GOOD ☐FAIR ☐POOR

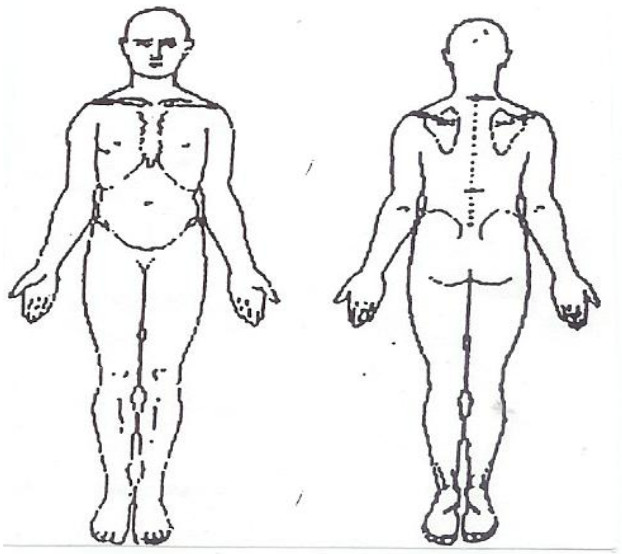
Mark using these symbols on the drawing the areas you feel:

↓ Shooting/sharp pain

O Dull/aching pain

||| Numbness

= Tingling



Thank you for telling us your history.
This enables us to provide you with the best possible treatment program.