ATLANTA FALCONS PHYSICAL THERAPY CENTERS

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MEDICAL HISTORY FORM

Full Name of Patient: **Date of Birth:** _____M_____D_____Y

Reason for Therapy: **Date of Injury/Symptoms:** _____M_____D_____Y

Chief Complaint/Concern: **Date of First Doctor Visit:** _____M_____D_____Y

Please indicate if you have received any of these services for your injury?

X-Ray	☐ Yes ☐ No	Myelogram	☐ Yes ☐ No	General Practitioner	☐ Yes ☐ No
MRI	☐ Yes ☐ No	Physical Therapy	☐ Yes ☐ No	Orthopedist	☐ Yes ☐ No
CT-Scan	☐ Yes ☐ No	Occupational Therapy	☐ Yes ☐ No	Neurologist	☐ Yes ☐ No
EMG	☐ Yes ☐ No	Massage Therapy	☐ Yes ☐ No	ER Care	☐ Yes ☐ No

Did you have surgery for this injury? If yes, please describe and provide the procedure date(s). If no, please write "none."

Have you ever experienced the following? (If yes is checked for any item, please describe on the reverse side of this form.)

General/Constitutional		**Cardiovascular**		**Musculoskeletal**	
Fatigue	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Muscle Pain/Cramps	☐ Yes ☐ No
Recent Weight Changes	☐ Yes ☐ No	Chest Pain	☐ Yes ☐ No	Stiffness	☐ Yes ☐ No
Night Sweats/Fevers	☐ Yes ☐ No	Coronary Artery Disease	☐ Yes ☐ No	Joint Pain or Swelling	☐ Yes ☐ No
Other:	☐ Yes ☐ No	Heart Surgery/Pacemaker	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Respiratory		**Neurological**		**Gastrointestinal**	
Shortness of Breath	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Nausea/Vomiting	☐ Yes ☐ No
Excessive Coughing	☐ Yes ☐ No	Seizures/Epilepsy	☐ Yes ☐ No	Abdominal Pain	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Numbness/Tingling	☐ Yes ☐ No	Rectal Bleeding	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No	Blood in Urine	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Weakness	☐ Yes ☐ No	Kidney Stones	☐ Yes ☐ No
Other:	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No	Other:	☐ Yes ☐ No
Endocrine		**Hematological/Lymphatic**		**Ophthalmological**	
Excessive Thirst/Urination	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No	Glasses/Contacts	☐ Yes ☐ No
Thyroid Disease	☐ Yes ☐ No	Slow to Heal	☐ Yes ☐ No	Blurred/Double Vision	☐ Yes ☐ No
Hormone Problem(s)	☐ Yes ☐ No	Enlarged Glands	☐ Yes ☐ No	Eye Disease/Injury	☐ Yes ☐ No
Other:	☐ Yes ☐ No	Other:	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No
Ear-Nose-Throat		**Other**		**Other**	
Hearing Loss or Ringing	☐ Yes ☐ No	Are you pregnant	☐ Yes ☐ No	HIV/AIDS	☐ Yes ☐ No
Sinus Problems	☐ Yes ☐ No	Breast Pain/Discharge	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Sore Throat	☐ Yes ☐ No	Menstrual Changes	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Voice Change	☐ Yes ☐ No	Blood Clot	☐ Yes ☐ No	Cancer	☐ Yes ☐ No
Allergies		Confusion/Memory Loss	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Food and Medical	☐ Yes ☐ No	Do you use tobacco	☐ Yes ☐ No	Other	☐ Yes ☐ No

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Please check here ☐ if you have any additional injury specific or medical history information to share on the reverse side of this form. Include details surrounding any pain you feel, prescription and non-prescription medicine you are currently taking, allergies and associated reactions, and other information to help your therapist customize the right treatment plan for you.

My signature below confirms that the information provided on this document is accurate to the best of my knowledge.

Patient Signature: **Printed Name:** **Date:**

Parent/Guardian's Signature: **Parent/Guardian's Name:** **Date:**

PATIENT COMMENTS:

THERAPIST COMMENTS: