Medical History

Name:_____ Age:_____ DOB:_____ Date:_____

Do you Smoke: YES NO Work Status:_____ Referring Physician:_____

Do you live in a ___ Apartment or ___ House? Do you live with someone? Spouse/Children/Caretaker/Other

Briefly describe your injury and/or complaint:_____

What is the date of onset of injury and/or complaint:_____ Diagnostic Tests: x-ray MRI CT EMG

Prior to the onset of your complaint, did you have any limitations with your daily activities? YES NO

If "YES", please list specific past limitations:_____

Please list your hobbies/recreational activities:_____

Please describe your main complaint/restriction:_____

Most comfortable activity/posture/position:_____

Least comfortable activity/posture/position_____

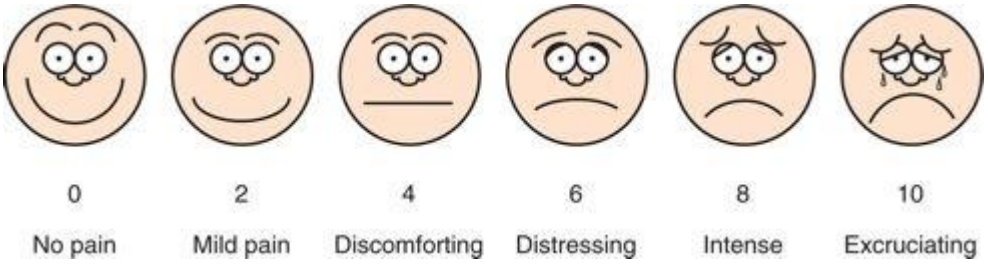
Nature of pain/symptoms (if applicable): sharp aching intermittent constant dull sharp throbbing

Since the onset, are your symptoms getting: better worse no change

As your day progresses, do your symptoms: increase decrease stay the same no pattern

Does pain wake you at night: YES NO

Select the appropriate response using the following pain scale: Current level_____ Worst_____ Least_____



Personal Medical History: Please circle the ones that apply

Cancer	Heart Conditions	Arthritis	Osteoporosis	Depression
Stroke/TIA	High Blood Pressure	Fractures	Balance Problems/Falls	Bladder problems
Diabetes	Thyroid problems	Head Injury	Epilepsy/Seizures	Parkinson's
Fibromyalgia	Multiple Sclerosis	Skin Diseases	Stomach problems	Circulation
Allergies	Rheumatoid Arthritis	Infections	Other:_____	

Medications (if you have a list, we can make a copy of it): See list;_____

_____

_____ _____

Patient Signature / Date Physical Therapist Signature / Date