CORE Physical Therapy

PATIENT MEDICAL HISTORY

Today's Date: _____

Name: _____ DOB: _____

Occupation:_____

Caffeine: Never Rarely # of cups per day

Alcohol: Never Quit current amount per day

Tobacco: Never Quit current amount per day

Exercise: Never Type/Frequency_____

HAVE YOU HAD PHYSICAL THERAPY IN THE CURRENT YEAR? ☐ YES ☐ NO

FOR MEDICARE PATIENTS
Are you receiving services from a Home Health Care Agency, Visiting Nurses Association, or residing in a skilled nursing facility? ☐ YES ☐ NO If yes, please explain.
_____

PAST SURGERY/INJURY **DATE**

_____

_____

XRAYS, MRI, CT SCAN: _____

MEDICATIONS:_____

ALLERGIES:_____

MARK ALL CURRENT DIAGNOSIS IN THE LIST BELOW:

☐ Diabetes_____ ☐ Hypertension_____

☐ Kidney disease_____ ☐ Thyroid_____

☐ Stroke_____ ☐ Lung disease_____

☐ Liver Disease_____ ☐ Cancer_____

☐ Heart Trouble_____ ☐ Mental Illness_____

1. Why are you seeking physical therapy services? Was this due to an accident?

_____

_____

2. How has this affected your ability to perform daily activities?

_____

_____

3. On a scale of 0 = no pain and 10 = the most severe pain imaginable, how would you rate your pain?
At this moment_____ At its worst _____ At its best _____