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PATIENT MEDICAL HISTORY

Today's Date: _____
Updated on: _____
Updated on: _____

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:_____

☐ 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 _____