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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: _____

- | | |
|---|---|
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hypertension _____ |
| <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Thyroid _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Lung disease _____ |
| <input type="checkbox"/> Liver Disease _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Heart Trouble _____ | <input type="checkbox"/> 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 _____