PATIENT MEDICAL HISTORY

Name ____ Date________________DOB ________________
Allergic to: ____ Bee Stings? Yes No Latex? Yes No
How would you rate your general health? Excellent Good Average Fair Poor
Do you currently or have you in the past 6 months received Home Healthcare Services? Yes No
Have you received chiropractic care in the past 6 months? Yes No
Have you had surgery or been hospitalized in the past 6 months? Yes No
If yes, when and why hospitalized? ____
Are you presently working? Yes No If working, is it: light/modified duty regular duty
What type of exercise do you regularly perform (prior to injury) and how often? ____________________
____
Have you ever had a broken bone or fracture? Yes No
If yes, which body part: ____________________________When:_________________________________
Is this a work-related injury? Yes No
What are your goals for physical therapy?
____
____

Physicians you are currently seeing:	**Reason:**
____________________________	____
____________________________	____
____________________________	____

Please circle the conditions you are currently experiencing or have experienced in the past:

Asthma	Chronic fatigue
Chronic cold hands and feet	Blood disorders
Frequent or severe headaches	Allergies
Sudden weight change Loss/Gain	Diabetes/Low blood sugar
Sinus Problems	Difficulty sleeping
Arthritis/Swollen joints	Heart condition
Bruise easily	Acid reflux
Leg Cramps	Drug/Alcohol problems
Pain or pressure in chest	Dizziness
Seizures	Fainting
High/Low Blood Pressure	Anemia
Stroke	Hearing problems
Osteoporosis	Head injury
Thyroid problems	Liver problems
Pregnant/Pregnancy	Coordination problems
Heart palpitations	Shortness of breath
Tobacco use	Infectious diseases
Kidney problems	Cancer/Tumor where? _____________

Please list your history of major illness or injuries, including Motor Vehicle Accidents:____
____
____

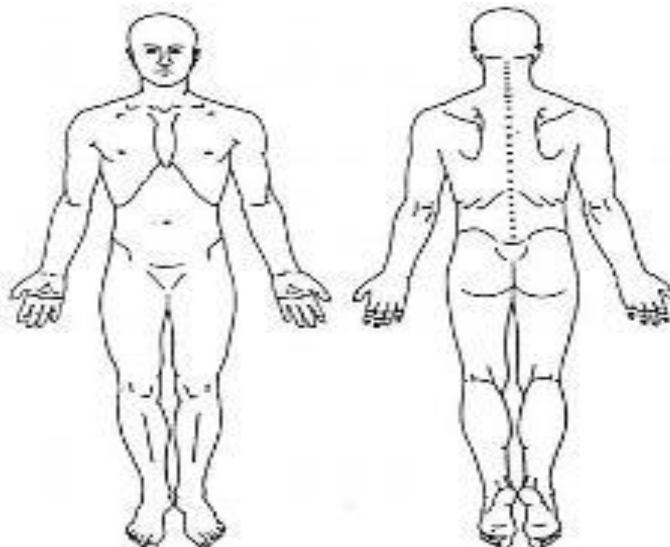
<u>MEDICATIONS:</u> (This includes prescriptions from your doctor, over the counter drugs, herbal and nutritional supplements) Separate List Provided? Yes No

<u>Medication/Drug Name/Strength/Times Every Day</u>

____
____
____
____
____
____
____
____
____

What are your present symptoms? ____
When did your symptoms begin? ____
Have you experienced these symptoms before? Yes No If yes, when? ______________________
Was the onset of this current episode? Gradual Sudden
Did you have any diagnostic tests recently? (MRI, x-rays, CT scan) Yes No
Circle which best describes your pain: Aching Stabbing Pins and Needle Numbness Burning

Mark the area of pain on chart



<u>HOW DID YOU HEAR ABOUT PIERCE PHYSICAL THERAPY? (PLEASE CIRCLE ALL THAT APPLY)</u>
Newspaper Physician Internet Website Church Bulletin
Family/Friend (Who? __________________________) Phonebook Insurance Company
Gym Home Health Event News Article Other ___________________