Medical History Information Sheet

Name_______________________________ Date_________________

1. What brings you here today? ____
2. What would you say is the average pain rating for your current condition using a scale of 0 – 10?
   (0 = no pain, 10 = worst pain imaginable) _________________

3. Do you now have or have you ever had the following? **Explain if answering yes to any.**

Yes ____ No ____ Stroke ____
Yes ____ No ____ High Blood Pressure _____________________________________
Yes ____ No ____ Asthma ____
Yes ____ No ____ Diabetes ____
Yes ____ No ____ Epilepsy/Fainting ______________________________________
Yes ____ No ____ Impairment of Vision or Hearing _________________________
Yes ____ No ____ Cancer ____
Yes ____ No ____ Allergies ____
Yes ____ No ____ Osteoporosis ____
Yes ____ No ____ High Cholesterol _______________________________________
Yes ____ No ____ Arthritis____

Orthopaedic History- Please give dates & treatments received:

4. Have you ever sprained, strained, dislocated or fractured the following?
   Head/Neck (including concussion) _______________________________________
   Trunk (ribs, vertebrae, sternum) ____
   Low Back (vertebrae, discs, nerves) _____________________________________
   Upper Extremity (shoulder, elbow, wrist, arm) _____________________________
   Lower Extremity (hip, leg, knee, ankle, foot) ______________________________
5. Please list any surgeries that you have had and their dates: ___________________________
____
6. Please list any cardiac history that we need to be aware of (heart disease, pacemaker, heart murmur, etc.): ____
7. Please list any medication(s) presently taking (including vitamins and supplements):
____
8. Women: Is there any chance you may be pregnant? Yes ____ No ____
9. Had you ever had PT in the past for the same issue? Yes ____ No ____
   If so, when? __________________ Name of the agency:__________________________
10. Do you exercise? Yes_____ No_____ What forms?_________________________________
11. Medicare only: Height ___________ Weight ___________
12. Overall my health is ____