

Physical Therapy Forum, Inc.

Confidential Medical History

Name: _____ Date: / /

Birth Date: / / Sex: M F Pregnant: Yes No N/A

Primary Physician: _____ Physician Phone :() _____

Medical Conditions: (Please check all that apply)

| | | |
|---|---|--|
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> Poor Eyesight |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Carpal Tunnel Right / Left | <input type="checkbox"/> Polio | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Tennis Elbow Right / Left | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Limited Limb Movement | <input type="checkbox"/> Epilepsy / Seizures | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Dislocation (Upper Extrem) | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Dislocation (Lower Extrem) | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Other: |

Medications / supplements you are currently taking:

Surgeries:

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |

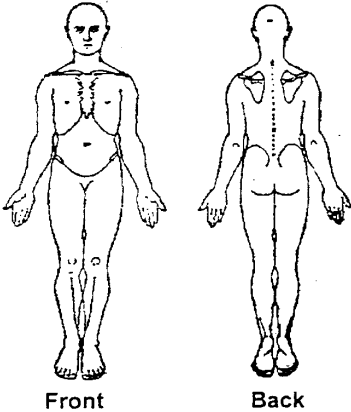
Other Hospitalizations:

| Year | Reason | Hospital |
|------|--------|----------|
| | | |
| | | |
| | | |

Current symptoms for which you are seeking treatment:

How long have you had these symptoms?
 Have you been treated for this before? Yes No

What activities can you not perform due to your current symptoms?

| | | | | | | | | |
|---|--|--------------------------------|-----------------------------------|-------------------------------|---------------------------------------|----------------------------------|------------------------------------|-------------------------------|
| <p>Location of pain: Please indicate the location of pain on the diagram to the right.</p> |  | | | | | | | |
| <p>Indicate level of pain: (circle one)</p> <p>No Pain <- 0 1 2 3 4 5 6 7 8 9 10 -> Severe Pain</p> | | | | | | | | |
| <p>Indicate type of pain (check all that apply):</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;"><input type="checkbox"/> Sharp</td> <td style="width: 50%;"><input type="checkbox"/> Constant</td> </tr> <tr> <td><input type="checkbox"/> Dull</td> <td><input type="checkbox"/> Intermittent</td> </tr> <tr> <td><input type="checkbox"/> Burning</td> <td><input type="checkbox"/> Radiating</td> </tr> <tr> <td><input type="checkbox"/> Ache</td> <td><input type="checkbox"/> Other _____</td> </tr> </table> | | <input type="checkbox"/> Sharp | <input type="checkbox"/> Constant | <input type="checkbox"/> Dull | <input type="checkbox"/> Intermittent | <input type="checkbox"/> Burning | <input type="checkbox"/> Radiating | <input type="checkbox"/> Ache |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Constant | | | | | | | |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Intermittent | | | | | | | |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Radiating | | | | | | | |
| <input type="checkbox"/> Ache | <input type="checkbox"/> Other _____ | | | | | | | |

What makes it better? _____

What makes it worse? _____

Effects of pain (impact on daily life, function, sleep, appetite, etc.):

What are your goals for treatment?

What treatments have you had in the past for these symptoms?

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

The information I have provided is accurate to the best of my knowledge. I will Advise the staff if there is any change in my medical condition that would alter my responses on this form.

X _____

PATIENT/GUARDIAN SIGNATURE
DATE