Patient Medical History

Name: _____ **Age:** _____ **Date of next Dr's appointment:** ____/____/____

Referring Physician: _____ **Doctor's Diagnosis:** _____

Your main concern:

_____

Are you presently working? ____Yes ____No **What is/was your occupation?** _____

Was your injury a result of an automobile accident? ___Yes ___No

Is this injury a work related injury? ___Yes ___No **If yes, when did the injury occur?**_____

If there an attorney involved in this case? ___Yes ___No

Please check any of the following whose care you are under:

_____Medical Doctor/Osteopath _____Physical Therapist _____Chiropractor _____Psychiatrist/Psychologist

_____Other:_____

Have you had any of the following tests for THIS condition? (If yes, please list date):

_____X-Rays _____MRI _____CAT scan _____Bone Scan _____ Nerve/Muscle test

_____Other_____

Please list any surgeries (in/out patient) and any conditions for which you have been hospitalized and the dates:

_____ ____/____/____ _____ ____/____/____

_____ ____/____/____ _____ ____/____/____

_____ ____/____/____ _____ ____/____/____

During the past month have you been feeling down, depressed or felt hopeless? ___Yes ___No

During the last month have you been bothered by having little interest or pleasure in doing things? ___Yes ___No

Would you like us to notify your physician or would you like a social services referral? ____Yes ____No

Women: Are you currently pregnant or think you might be pregnant? ___Yes ___No

Please list any PRESCRIPTION medications you are currently taking:

1._____ 2._____

3._____

4._____ 5._____

6._____

Have you EVER been diagnosed as having any of the following conditions? Please circle those that apply.

Anemia	Emphysema/Bronchitis	Multiple Sclerosis	Sleeping Problems
Asthma	Gout	Orthopedic Surgery	Stroke
Cancer	Headaches	Osteoporosis	Thyroid Problems
Chemical Dependency (i.e. Alcoholism)	Heart Problems	Pace Maker	Tuberculosis
Circulation Problems	Hepatitis	Rheumatoid Arthritis	Vision/Hearing Problems
Depression	High Blood Pressure	Seizures/Epilepsy	Weight/Energy Loss
Diabetes	Kidney Disease		

Have you recently noted:

Weight loss/gain	**Yes**	**No**	**Fever/Chills/Sweats**	**Yes**	**No**
Nausea/Vomiting	**Yes**	**No**	**Numbness or Tingling**	**Yes**	**No**
Dizziness/Lightheadedness	**Yes**	**No**	**Night Pain**	**Yes**	**No**
Fatigue	**Yes**	**No**	**Weakness**	**Yes**	**No**

Please indicate your goals for physical therapy: _____

_____

I do hereby state that the above information is accurate and true to the best of my knowledge.

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

(If other than patient, please list relationship)