Print Form

Medical History

Please provide us with your medical history to assist your therapist in providing a thorough initial evaluation and treatment plan. Please answer all questions.

This form may be filled out "online" and printed to your local printer.

Today's Date:

Your Name: Date of Birth: Age: Gender:

Occupation: Leisure Activities

Reason for today's visit:

Date problem first occured: Have you had any previous similar problems?

If Yes, please explain:

Are you employed? If YES, are you able to work? Go to work by:

How many minutes do you spend in a vehicle each day?

Do you smoke? If YES, how many packs of cigarettes do you smoke per day?

I live: In a: With bedroom on the: Bathroom on the:

Do you have stairs in your house? Have you had physical therapy in the past 12 months?

Have you ever been diagnosed as having any of the following conditions?

- Anemia
- Asthma
- Blood Clot/Thrombosis (DVT)
- Chemical Dependency (e.g. alcoholism)
- Circulation Problems
- Depression
- Cancer If YES, what kind?
- Heart Problems If YES, describe?
- Thyroid Problems If YES, describe?
- Diabetes
- Emphysema
- Epilepsy
- Hepatitis
- High Blood Pressure (HTN)
- Kidney Disease
- Multiple Sclerosis (MS)
- Parkinson's Disease
- Rheumatoid Arthritis
- Stroke
- Tuberculosis (TB)

Other arthritic conditions?

Other?

Have you taken any OVER-THE-COUNTER medication in the past month?

Advil/Motrin/Ibuprophen? Antihistamines? Aspirin? Decongestants?

Tylenol? Vitamins/Mineral Supplements? Other?

Please list any PRESCRIPTION medication that you are currently taking?

1. 2.

3. 4.

5. 6.

Are you allergic to Latex? Please list any other allergies:

What is your current status with the following activities of daily living?

Bathing Eating

Toileting Driving Other?

Showering Walking Other?

Dressing Sitting

Cooking Standing

What are your functional goals for treatment? (ex. I would like to be able to stand long enough to take a shower. OR I would like to be able to drive to work for 30 minutes without being in pain from sitting too long.)

☐ **I have not had any surgeries** (Please skip to next section, Please answer if you have had any surgeries)

Please list any surgeries or any other conditions for which you have been hospitalized:

Date (approximate): Reason for hospital stay:

Date (approximate): Reason for hospital stay:

☐ **I have not had any injuries/conditions** (Please skip to next section, Please answer if you have had any injuries)

Please describe any injuries or conditions for which you have been treated:

Date (approximate): Reason for treatment::

Date (approximate): Reason for treatment:

DURING THE PAST MONTH:

Have you been bothered by having little interest or pleasure in doing things?

Have you been feeling down, depressed, or hopeless?

FOR WOMEN:

Are you currently pregnant or think that you might be pregnant?

☐ **I do not have any pain** (Please skip to next section, if you do have pain please answer the following questions)

How would you rate your pain on a scale of 1 - 10 with 0 representing no pain and 10 representing the worst pain possible

How many hours are you in pain each day?

How many hours of sleep did you get last night?

Is your pain effecting your sleep?

Describe your pain?

What increases your pain? (Check all that apply)

☐ Walking ☐ Sitting ☐ Ascending Stairs ☐ Carrying Objects ☐ Vacuuming
☐ Standing ☐ lifting ☐ Descending Stairs ☐ Pushing Objects ☐ Driving

Other:

What decreases or relieves your pain? (Check all that apply)

☐ Walking ☐ Sitting ☐ Stretching ☐ Exercise ☐ Ice Application
☐ Standing ☐ Rest ☐ Sleeping ☐ Massage ☐ Heat Application

Other:

Are you under the care of any of the following?:

☐ Medical Doctor (MD) ☐ Physical Therapist ☐ Psychiatrist ☐ Acupuncturist
☐ Osteopathic Doctor (DO) ☐ Chiropractor ☐ Psychologist

Other:

If you have been seen by any of the above for the past six months, please describe the reason for the visit(s):

Have you recently experienced:

Numbness? If YES, describe?

Tingling? If YES, describe?

Unexplained weight loss/gain?

Dizziness/Lightheadedness?

Nausea/Vomiting?

Weakness?

Changes in frequency of bowel movements?

Shortness of breath?

Difficultly Urinating?

Fatigue?

Changes in frequency of urination?

Fever/Chills/Sweats?

Please let us know about any other health care concerns below:

To the best of my knowledge the questions on this form have be accurately answered. I understand that providing inaccurate information can be dangerous to my health. It is my responsibility to inform my therapist of any change in my medical status. I authorize the health care staff to perform the services I need.

Signature _____

Person Completing Form If NOT Patient _____ Relationship to patient

Print Name

Thank you for taking the time to fill out our online Medical History form. Please use the print button located below to print to your local printer. After printing be sure to review your answers. Also, remember to bring the completed form with you on your first visit. Any questions please call (732) 329-1181.

Print Form