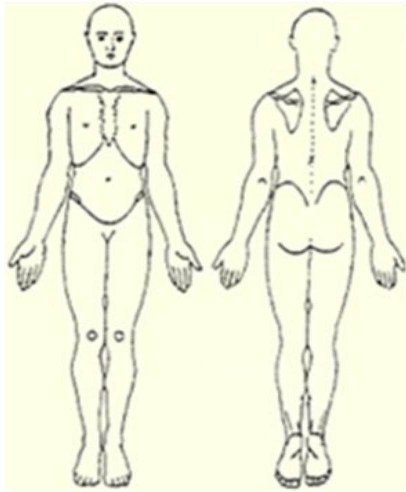
MEDICAL HISTORY AND PHYSICAL CONDITION

BMI—Office Use Only

W__________ # H_________Inches

Patient Name: ____

1. Please describe the problem indicated on your prescription: ______________________________
2. Please give approximate date when symptoms first appeared: ______________________________



Where is your pain? ____

Is your pain _________ **constant** **or** _________ **intermittent?**

Describe your pain: ____

____

Pain Scale: **No pain** = 0 1 2 3 4 5 6 7 8 9 10 = **Worst possible**

Worst pain level = ______ Current pain level = _______ Lowest pain level = _______

Please mark the chart to the left if/where you are experiencing:

P=Pain **N= Numbness** **T= Tingling** **W= Weakness**

3. If you have pain/symptoms in more than one area, which area is worst? ______________________
4. Do you have difficulty voiding or controlling bowel/bladder? □ Yes □ No
5. When are symptoms worse? □ Morning □ Afternoon □ Evening □ Night □ Sleep Disturbed
6. What makes your symptoms **worse**:

   □ Coughing □ Sneezing □ Bending □ Lifting □ Head Movement □ Arm Movement

   □ Sitting—how many minutes ___ □ Standing—how many minutes ___ □ Walking– how many minutes ___

   □ Other: ____

7. What makes your symptoms **better**:

   □ Sitting—how many minutes ___ □ Standing—how many minutes___ □ Walking– how many minutes ___

   □ Bending forward Lying down on my □ Side □ Back □ Stomach

   □ Other: ____

8. Have you ever had these symptoms in the past? □ Yes □ No If so, when? ____________________
9. Are your symptoms: □ Getting worse □ Getting better □ Staying the same
10. Have you had any treatment for this problem?

    □ **Injections** When? ________________ Helpful? □ Yes □ No

    □ **Physical Therapy** When? ________________ How many treatments? _______ Helpful ? □ Yes □ No

    □ **Chiropractic** When? ________________ How many treatments? _______ Helpful ? □ Yes □ No

    □ **Surgery** When? ________________ Type ______________________ Helpful ? □ Yes □ No

    □ **Other** ____

11. Have you had any diagnostic tests for this problem?

    □ X-rays / When? _____________ □ Bone Density / When? ____________ □ CT Scan / When? __________

    □ MRI / When? ______________ □ Nerve Conduction Velocity Test / When? _______________

    □ Other ____

(CONTINUED ON REVERSE →)

Current and Past Medical History (Please check all that apply)

☐ Allergies	☐ Balance Difficulties	☐ Cardiac Arythmia	☐ Cognitive Impairments
☐ Diabetes	☐ Dizzy Spells	☐ Depression	☐ High Blood Pressure
☐ Headaches	☐ Hearing Problems	☐ Hernia	☐ HIV/AIDS
☐ Heart Attack	☐ Heart Problems / What type ______________________________		
☐ Kidney Disease	☐ Lung/Breathing Problems	☐ Osteoporosis	☐ Pacemaker
☐ Pregnancy	☐ Seizures	☐ Stroke	☐ Vascular Disease
☐ Vision Problems	☐ Broken Bones ______________________		☐ Long-term steroid use (3 mos.)

☐ Motor Vehicle Injury/When ________________ ☐ Other Injury/What ____________________________

☐ Cancer: Type ______________________ When ____________ Current Status ____________________

Did you have: ☐ Chemotherapy ☐ Radiation ☐ Surgery

12. Do you have any metal implants?

☐ Hip (R / L) ☐ Knee (R / L) ☐ Back ☐ Shoulder (R / L) ☐ Other ____________________________

13. What is your occupation? ____

Employed: ☐ Full– time ☐ Part-time ☐ Not currently working

Out of work since: ______________________ Plan to return to work on: ____________________

14. Is there litigation involved with your problem? ☐ Yes ☐ No

15. What type of regular exercise do you do? ____

16. Do you smoke? ____

17. Please list medications and dosage you are taking or provide a list for our records:

Medication	Dosage	Medication	Dosage

18. What are your expectations / goals for Physical Therapy?

____

If you are a Medicare patient, have you recently had care from a Home Health Agency? ____________________

If so, please provide the name of your Health Care Provider: _______________________________________

Name of Home Health Agency: ____ Phone: ______________

Address: ____

Date of discharge from Home Health Agency: ____

Have you had ANY other Physical Therapy or Speech Therapy ANYWHERE this year? ____________________

The above information is correct, complete and to the best of my knowledge

____ ___________________________

Signature Date