Patient Medical History

Name:_________________________________

Have you had surgery for this injury? Y N **Date first seen for this injury:_____________________**

Type of surgery:________________________ **Number of surgeries: 1 2 3 4 ____**

Do you feel you have been made aware of your diagnosis? Yes No

Based on your awareness, what are you goals and expectations from physical therapy?

____

Have you had any of the following medical or rehabilitative services for <u>this</u> injury or episode?

	Yes	No		Yes	No
Physical Therapy	___	___	MRI	___	___
Massage Therapy	___	___	X-Rays	___	___
Chiropractic	___	___	CT Scan	___	___
Podiatrist	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Injections	___	___
Other:___________________________					

Do you <u>NOW</u> have any of the following?

	Yes	No		Yes	No
Asthma, Bronchitis, Emphysema	___	___	Severe or frequent headaches	___	___
Shortness of breath/chest pain	___	___	Numbness or Tingling	___	___
High Blood Pressure	___	___	Dizziness or Fainting	___	___
Epilepsy/Seizures	___	___	Bowel or Bladder Problems	___	___
Anemia	___	___	Weakness/Energy loss	___	___
Diabetes/Type___	___	___	Any pins or metal implants	___	___
Arthritis/Where___	___	___	Emotional/Psychological	___	___
Osteoporosis	___	___	Are you Pregnant	___	___
Sleeping difficulties	___	___	Do you smoke	___	___

Have you <u>EVER</u> had any of the following?

	Yes	No		Yes	No
Coronary heart disease/Angina	___	___	Vision or Hearing Difficulties	___	___
Do you have a pacemaker	___	___	Hernia	___	___
Heart Attack/Surgery	___	___	Varicose Veins	___	___
Stroke/TIA	___	___	Allergies	___	___
Congestive heart disease	___	___	Joint replacement surgery	___	___
Blood clot/Emboli	___	___	Neck injury/surgery	___	___
Infectious Disease	___	___	Back injury/surgery	___	___
Cancer/Type_____	___	___	Shoulder injury/surgery	___	___
Gout	___	___	Knee injury/surgery	___	___
Ankle/foot injury/surgery	___	___	Elbow/hand injury/surgery	___	___

Patient/Guardian:_________________________________ Date:______________________