

Medical History

To ensure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your physical therapist will assist you. Thank you.

Name: _____

What is your complaint or problem? _____

When did your problem begin? _____

What do you hope to achieve with PT? _____

Height: _____ Weight: _____

Pain? No Yes (If yes, where and intensity 0-10, 0 no pain - 10 most severe pain) _____

Allergies? No Yes (to what?): _____

Any falls over last 12 months? No Yes (how often?): _____

Past Medical History		
Do you now or have you ever had :		
<input type="checkbox"/> Diabetes (type): _____ <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Congestive Heart Failure/cardiac edema <input type="checkbox"/> Heart Attack <input type="checkbox"/> Varicose veins <input type="checkbox"/> Venous Insufficiency <input type="checkbox"/> Hypothyroidism <input type="checkbox"/> Hyperthyroidism <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Auto-immune disease <input type="checkbox"/> Migraines <input type="checkbox"/> Back pain <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Altered sensation <input type="checkbox"/> Wound(s) <input type="checkbox"/> Latex Allergy <input type="checkbox"/> Cancer (type): _____	<input type="checkbox"/> Epilepsy/Seizures <input type="checkbox"/> Double Vision <input type="checkbox"/> Macular Degeneration <input type="checkbox"/> Vision Impairments <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Hepatitis <input type="checkbox"/> Liver disease <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Asthma <input type="checkbox"/> COPD <input type="checkbox"/> Cellulitis <input type="checkbox"/> Active infection <input type="checkbox"/> Abdominal aortic aneurysm <input type="checkbox"/> Diverticulitis <input type="checkbox"/> Severe arteriosclerosis (ABI 0.49 or less) <input type="checkbox"/> Inflammatory bowel <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Ulcerative colitis <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hyper-flexibility	<input type="checkbox"/> Scoliosis <input type="checkbox"/> Parkinson's Disease <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Traumatic Brain Injury <input type="checkbox"/> Stroke/TIA <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Bipolar <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Psychiatric Illness <input type="checkbox"/> Dementia/Alzheimer's <input type="checkbox"/> Asperger's/Autism <input type="checkbox"/> Skin Disorder <input type="checkbox"/> Blood Clots <input type="checkbox"/> Ehlers-Danlos Syndrome <input type="checkbox"/> Urinary Incontinence <input type="checkbox"/> Currently Pregnant <input type="checkbox"/> Breast Feeding <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Other: _____ _____ _____

Past Surgical History (include date of surgery)	

Medication List (Including Over the Counter) (Please list name of drug, dosage, and frequency)	

Social		
Lives with: <input type="checkbox"/> Alone <input type="checkbox"/> _____	Stairs at Home: <input type="checkbox"/> None <input type="checkbox"/> # of stairs: _____	Daily Task: <input type="checkbox"/> Cooking <input type="checkbox"/> Cleaning <input type="checkbox"/> Pet care <input type="checkbox"/> Childcare <input type="checkbox"/> Working a job <input type="checkbox"/> Yard work <input type="checkbox"/> Snow removal
Occupation:		
Physical Demands Required for Job:		

Equipment at Home		
<input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Electric Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Grab Bars in Shower <input type="checkbox"/> Grab Bars by Toilet <input type="checkbox"/> Raised Toilet Seat	<input type="checkbox"/> Shower Chair/Bench <input type="checkbox"/> Reacher <input type="checkbox"/> Bedrails <input type="checkbox"/> Bedside Commode <input type="checkbox"/> Compression Hose <input type="checkbox"/> Compression Wraps	<input type="checkbox"/> Hospital Bed <input type="checkbox"/> Standard Walker <input type="checkbox"/> Walker with Seat <input type="checkbox"/> Single Point Cane <input type="checkbox"/> Quad Cane <input type="checkbox"/> Gait Belt

Current Exercise: _____

Exercise Equipment Available to me: _____