Patterson Physical Therapy

Medical History Form

Name: ___________________________ Date: _________ Date of Birth: ________ Age: _____ Height:______

Weight: ______ Referring Physician: ___________________________ Treatment Side: **Left** **Right** **N/A**

Date of Injury/Change of Status:____

Surgery Performed? **Yes** **No** Date of Surgery: ____________ Type of Surgery_______________________

History of Present Condition/ Mechanism of Injury: ____

Primary Concern/ Chief Complaint:____

Functional Limitations (Circle all that apply) Sleep Self Care Reaching/Pushing/Pulling
Lifting/Carrying Bending Sitting Standing
Walking Squatting

Pain Location: ____

Pain at Worst	0	1	2	3	4	5	6	7	8	9	10
Pain Right Now	0	1	2	3	4	5	6	7	8	9	10
Pain at Best	0	1	2	3	4	5	6	7	8	9	10

0 = No Pain
5 = Moderate Pain
10 = Extreme Pain

Pain Description: Burning Throbbing Dull Achy Stabbing Shooting Other: ________________

Aggravating Factors (Circle all that apply) Sitting Standing Walking Stairs - up
Stairs - down Sit to Stand Bending
Laying Cough/ Sneeze

How do you manage your pain? Ice______ Heat _______ Other ________________________________

Occupation/Work Status: Full time ____ Part time ____ Not Employed ____ Occupation: ________________

History of Falls? **Yes** **No** If Yes, explain: _______ Date of Fall:_______________________________

Medical History: (Circle all that apply):

Osteoarthritis Heart Disease Diabetes Type 1 Diabetes Type 2 Allergies
High Blood Pressure Pacemaker Cancer Mental Health Visual Impaired
Epilepsy HIV/AIDS Arthritis Fibromyalgia Stroke
Asthma Hearing Impaired Scoliosis Osteoporosis Hepatitis Pregnant

Other: ____

Surgical History: ____

Diagnostic Testing: ____

Are you exercising at home? **Yes** **No** If Yes, what type? ____

Do you smoke? **Yes** **No** When are you scheduled to see your doctor again? __________________________

Patient Goals/ What do you have to gain from PT?: ____

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To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy services at Patterson Physical Therapy.

Patient Signature: _________________________ Therapist Signature: _________________________