OnetoOne
PHYSICAL THERAPY & AQUATICS
The doctors' choice for personalized care

Medical History Form

(Please Print)

All information contained in this questionnaire is strictly confidential and will become part of your medical record.

Today's Date: _____

Patient's Name: Last _____ **First** _____ **Middle** _____

Address listed with your Insurance Co:_____ **City:**_____ **Zip Code:** _____

Local Address if different than above:_____**City:**_____ **Zip Code:** _____

Home Phone # _____ **Cell #** _____ **Work #** _____

Birth Date: / / **Age:** _____ **SS#** _____ **Sex:** ☐ **M** ☐ **F**

Height: _____ **Weight:** _____

We like to keep in touch with our patients by providing them with information and news about One To One Physical Therapy & Aquatics. Please provide your email address so that we may send you updates and important information:

Email Address: _____

How would you like to be Notified of your next appointment? Email Above ☐ **Cell #** ☐

How Did You Hear About Us?

- ☐ **Doctor Referred** ☐ **Insurance Company Referred**
- ☐ **External Signage or Advertisement:** _____
- ☐ **Promotional Piece(Postcard, Newsletter, Bday Card):** _____
- ☐ **Referred by Friend (please name here):** _____
- ☐ **Self Referred(Walk In, Been here in the last 6 months, Internet):** _____
- ☐ **Other (please list here):**_____

Have you had Home Health Care? ☐ **No** ☐ **Yes** **If yes, name of agency:** _____

Last date seen by Home Health Care: _____

Have you been involved in an Automobile accident within the last year? _____

Do you have an attorney representing you? _____ **If yes, who?** _____

Have you had, or currently have any of the following?

MEDICAL HISTORY

Allergies	**O Yes**	**O No**	**Depression**	**O Yes**	**O No**	**Multiple Sclerosis**	**O Yes**	**O No**
Anemia	**O Yes**	**O No**	**Diabetes**	**O Yes**	**O No**	**Osteoporosis**	**O Yes**	**O No**
Anxiety	**O Yes**	**O No**	**Dizzy Spells**	**O Yes**	**O No**	**Parkinson's**	**O Yes**	**O No**
Arthritis	**O Yes**	**O No**	**Emphysema/Bronchitis**	**O Yes**	**O No**	**Rheumatoid Arthritis**	**O Yes**	**O No**
Asthma	**O Yes**	**O No**	**Fractures**	**O Yes**	**O No**			
Cancer	**O Yes**	**O No**	**Gallbladder Problems**	**O Yes**	**O No**	**Seizures**	**O Yes**	**O No**
Cardiac Conditions	**O Yes**	**O No**	**Hepatitis**	**O Yes**	**O No**	**Speech Problems**	**O Yes**	**O No**
Cardiac Pacemaker	**O Yes**	**O No**	**High Blood Pressure**	**O Yes**	**O No**	**Strokes**	**O Yes**	**O No**
Chemical Dependency	**O Yes**	**O No**	**Incontinence**	**O Yes**	**O No**	**Thyroid Disease**	**O Yes**	**O No**
Circulation Problems	**O Yes**	**O No**	**Kidney Problems**	**O Yes**	**O No**	**Tuberculosis**	**O Yes**	**O No**
Currently Pregnant	**O Yes**	**O No**	**Metal Implants**	**O Yes**	**O No**	**Vision Problems**	**O Yes**	**O No**

Falls History

Injury as a result of a fall in the past year? ☐ Yes ☐ No Date of Fall:_____

Two or more falls in the last year? ☐ Yes ☐ No Dates of Falls:_____

Surgical History

Body Region: _____ **Surgery Type:** _____ **Date of Surgery:**_____
Body Region: _____ **Surgery Type:** _____ **Date of Surgery:**_____
Body Region: _____ **Surgery Type:** _____ **Date of Surgery:**_____
Body Region: _____ **Surgery Type:** _____ **Date of Surgery:**_____
Body Region: _____ **Surgery Type:** _____ **Date of Surgery:**_____

Current Medications

Drug: _____ **Dosage:** _____ **Reason for Taking:**_____
Drug: _____ **Dosage:** _____ **Reason for Taking:**_____
Drug: _____ **Dosage:** _____ **Reason for Taking:**_____
Drug: _____ **Dosage:** _____ **Reason for Taking:**_____
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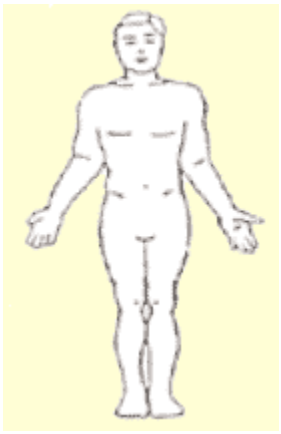
Drug: _____ **Dosage:** _____ **Reason for Taking:**_____
Drug: _____ **Dosage:** _____ **Reason for Taking:**_____

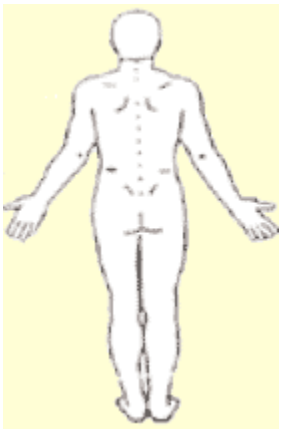
Medication Allergies

Drug: _____ **Reaction You Had:** _____
Drug: _____ **Reaction You Had:** _____
Drug: _____ **Reaction You Had:** _____
Drug: _____ **Reaction You Had:** _____
Drug: _____ **Reaction You Had:** _____
Drug: _____ **Reaction You Had:** _____

Drug: _____ **Reaction You Had: _____**

Pain Assessment:
Place a circle on the body images to indicate where you have pain.





The pain feels like (check all that apply)

Aching	Sharp
Burning	Stabbing
Dull	Throbbing
Numbing	Tender
Pressure	Tingling
Prickling	

Functional Status Form

Patient's Name: Last _____ First _____ Middle _____