# Medical History Form

| Patient Name: | Today's Date: | |
|---|---|---|
| Referring Physician: | Date of Birth: | Age: |
| Primary Care Physician: | Date of Injury or Onset: | |
| Date of Next Physician Appointment: | | |

**Reason for Therapy:**

**Cause of Injury or Onset**: ☐ Accident ☐ Auto ☐ Work ☐ Other: **If Other, please explain**:

**Have you been hospitalized for the present condition?** ☐ Yes ☐ No **If Yes, date**:

**Did you have surgery for this condition?** ☐ Yes ☐ No **If Yes, date**:
If Yes, surgery type:

**Are you currently receiving any other care for the condition mentioned above?** ☐Yes ☐No
If Yes, please describe:

**Have you ever received therapy in the past for the condition mentioned above**? ☐Yes ☐ No **If Yes, date:**
**Describe previous treatment:**

**Previous Treatment**: ☐Successful ☐Unsuccessful

**Have you fallen in the last year?** ☐ Yes ☐ No **If Yes, how many times?** **If Yes, were you injured?** ☐ Yes ☐ No
**Do you feel unsteady when standing or walking?** ☐ Yes ☐ No **Do you worry about falling?** ☐ Yes ☐ No

**What are your personal goals/outcomes you hope to achieve from therapy?**

**Describe your general health:** ☐ Excellent ☐ Good ☐ Fair ☐ Poor **Do you smoke or use tobacco?** ☐ Yes ☐ No

**DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)**

| | | |
|---|---|---|
| ☐ **Allergies** ☐ **Latex** ☐ **Other** | ☐ **Dizziness** | ☐ **Kidney Problems** |
| ☐ **Anemia** | ☐ **Epilepsy or Seizure Disorder** | ☐ **Metal Implants** |
| ☐ **Anxiety or Panic Disorders** | ☐ **Fainting** | ☐ **MRSA** |
| ☐ **Arthritis** ☐ **OA** ☐ **RA** | ☐ **Fatigue or Weakness** | ☐ **Multiple Sclerosis** |
| ☐ **Asthma** | ☐ **Fever or Chills** | ☐ **Nausea / Vomiting** |
| ☐ **Use of Blood Thinners** | ☐ **Fractures** | ☐ **Osteoporosis** |
| ☐ **Bowel or Bladder Disorder** | ☐ **Headaches** | ☐ **Pacemaker** |
| ☐ **Bleeding Disorder** | ☐ **Head Injury or Concussion** | ☐ **Parkinson's Disease** |
| ☐ **Cancer** | ☐ **Hearing Impairment** | ☐ **Peripheral Vascular Disease** |
| ☐ **Chronic Cough** | ☐ **Heart Disease or Heart Attack** | ☐ **Respiratory or Breathing Problems** |
| ☐ **COPD** | ☐ **Hepatitis** ☐ **A** ☐ **B** ☐ **C** | ☐ **Ringing in Ears** |
| ☐ **Congestive Heart Failure** | ☐ **Hernia** | ☐ **Sexual Dysfunction** |
| ☐ **Currently Pregnant** | ☐ **Blood Pressure** ☐ **High** ☐ **Low** | ☐ **Skin Abnormalities** |
| ☐ **Deep Vein Thrombosis (DVT)** | ☐ **HIV or AIDS** | ☐ **Stroke or TIA** |
| ☐ **Depression** | ☐ **Hypoglycemia** | ☐ **Thyroid Problems** |
| ☐ **Diabetes** ☐**Type I** ☐ **Type II** | ☐ **Hypersensitivity to Hot or Cold** | ☐ **Tuberculosis** |

**List any other medical problems and explain:**

# Medical History Form

| Medication List | | | |
|---|---|---|---|
| **Name of Medication** | **Dosage** | **Frequency** | |
| ☐ Check Box if Medication List provided separately. | | | |
| 1. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 2. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 3. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 4. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 5. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 6. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 7. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 8. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 9. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 10. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 11. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |
| 12. | | | ☐ Injection ☐ Oral ☐ Topical ☐Other |

**Over the Counter Medications (check all that apply):** ☐ Aspirin/Ibuprofen ☐ Antacids ☐ Sleeping Aids ☐ Cold Medicine: ☐ Cough Medicine ☐ Allergy Relief ☐ Laxative ☐ Diet Pills ☐ Vitamins/Herbal Supplements ☐ Other:

**Pain Scale**

Rate the severity of your pain by circling a box on the following scale.

No Pain — Worst Pain

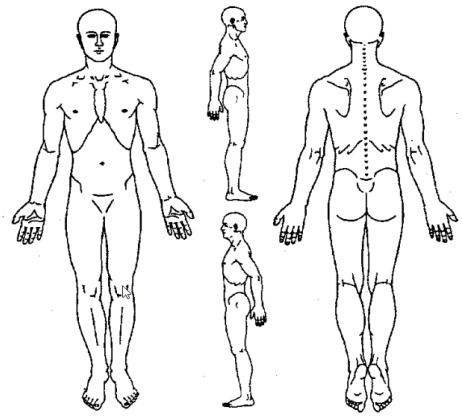
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|

**On the Body Diagram mark where you are experiencing symptoms, right now. Use the letters below to indicate the type and location.**

**KEY:**

A = Aching B = Burning N = Numbness

P = Tingling S = Stabbing O = Other



| **Signature of Patient:** | **DOB:** |
|---|---|
| **Printed Name of Patient:** | **Date:** |