Patient Medical History

Name: _____ **Age:** _____ **Date of next Dr's appointment:** ____/____/____

Referring Physician: _____ **Doctor's Diagnosis:** _____

Your main concern: _____

Are you presently working? ____Yes ____No **What is/was your occupation?** _____

Was your injury a result of an automobile accident? ___Yes ___No

Is this injury a work related injury? ___Yes ___No **If yes, when did the injury occur?**_____

If there an attorney involved in this case? ___Yes ___No

Please check any of the following whose care you are under:

_____Medical Doctor/Osteopath _____Physical Therapist _____Chiropractor _____Psychiatrist/Psychologist

_____Other:_____

Have you had any of the following tests for THIS condition? (*If yes, please list date*):

_____X-Rays _____MRI _____CAT scan _____Bone Scan _____ Nerve/Muscle test

_____Other_____

Please list any surgeries (in/out patient) and any conditions for which you have been hospitalized and the dates:

_____ ____/____/____ _____ ____/____/____

_____ ____/____/____ _____ ____/____/____

_____ ____/____/____ _____ ____/____/____

During the past month have you been feeling down, depressed or felt hopeless? ___Yes ___No

During the last month have you been bothered by having little interest or pleasure in doing things? ___Yes ___No

Please list any PRESCRIPTION medications you are currently taking:

1._____ **2.**_____ **3.**_____

4._____ **5.**_____ **6.**_____

Have you EVER been diagnosed as having any of the following conditions? Please circle those that apply and provide an explanation if necessary.

Alcohol addiction	Broken bones	Fatigue	Kidney disease	Paralysis
Anemia	Cancer	Female health challenges	Liver disease	Pneumonia
Arrhythmia	Carpal Tunnel	Gallbladder disease	Lung disease	Prostat problems
Arthritis	Colitis	Glaucoma	Menstrual cramps	Psychiatriac care
Asthma	Circulation problems	Gout	Mental disorder	Rheumatoid Arthiritis
Backaches	Depresssion/Anxiety	Headaches	Migranes	Seizures/Epilepsy
Bleeding disorder	Diabetes	Heart problems	Multiple Sclerosis	Stress/Tension
Blood dots	Digestive disorders	Hemorrhoids	Neck pain	Stroke
Blood transfusions	Dizziness	Hepatitis	Night sweats	Thyroid problems
Blurred Vision	Eating disorder	High blood pressure	Orthopedic surgery	Tuberculosis
Bronchitis	Emphysema	HIV/AIDS	Osteoporosis	Vision/Hearing problems
Bowel problems	Epilepsy	Joint pain	Pacemaker	Weight/Energy Loss

Explanation:_____

_____

_____

_____

Accident History: (Slips/falls/sports related injuries/auto accidents)

Accident: _____ Date: _____

Accident: _____ Date: _____

Accident: _____ Date: _____

Women: Are you currently pregnant? _____YES _____ NO. If you become pregnant during the course of physiotherapy or massage treatment, please inform your therapist immediately.

Please indicate your goals for physical therapy: _____

_____

_____

I do hereby state that the above information is accurate and true to the best of my knowledge.

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

(If other than patient, please list relationship)

Patient Complaint

Please complete this complaint form. Further questioning & probing, along with a full physical exam will take place with your Physiotherapist.

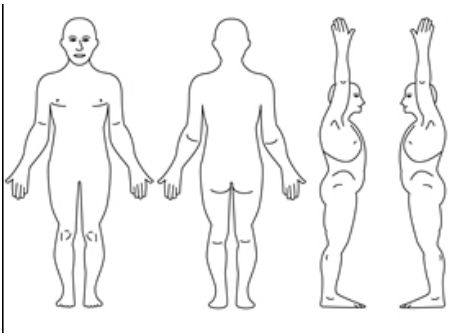
What is your primary complaint? (Onset-How-Progression-Location)

_____

_____

_____

Locate the symptoms (Please mark with an 'X' or circle the location):



Describe the symptoms:

□ ache □ burning □ dull □ sharp □ stiff/tight □ numb □ shooting □ throbbing □ tingling □ weakness

□ other: _____

Pain Scale: _____

(0 No Pain – 10 Unbearable)

Frequency of pain? □ Constant / □ Intermittent

Does the pain radiate?

□ Yes / □ No.

If yes where? _____

I do hereby state that the above information is accurate and true to the best of my knowledge.

_____ _____/_____/_____

Signature of Patient or Guardian **Date**

(If other than patient, please list relationship)