Therapy Services Medical History Form

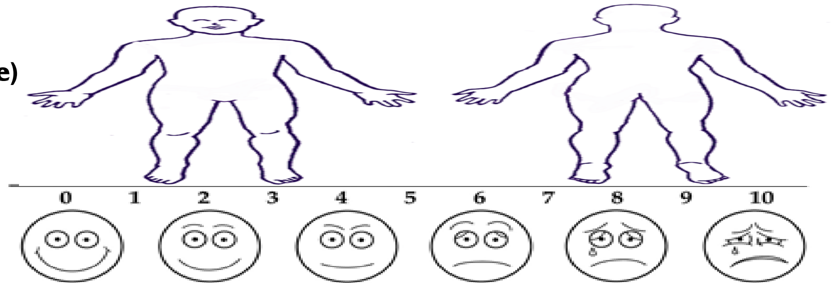
Instructions: Please fill out the following form completely. If you need assistance, please ask our office staff.

Name (Printed) ____

Date of Recent Injury ____/____/____ **Date of Surgery (if applicable)** ____/____/____

Circle area of injury/pain
"X" area of numbness/tingling (if applicable)

Average day pain level __________/10
Worse pain of the day level ________/10
Frequency of pain □Constant □Intermittent



Primary Care Physician: ______________________________________
Referring Physician (if different than Primary Care): ____________________

Are you receiving therapy services anywhere else currently (including at your home)? □ Yes □No
Have you had therapy in the past for this same injury/condition? □ Yes □No

What tests/procedures have been done for your current condition?
□X-Rays □MRI/CT Scan □Bone Scan □EMG □Blood Work □Other

Activities you are having trouble with because of your current injury?

□Sitting	□Standing	□Walking	□Up/Down Stairs	□Grooming	□Dressing
□Housework	□Yard work	□Driving	□Up from Chair	□Bathing	□Sleeping

What are your goals for attending therapy?
□Pain relief □Improve strength □Improve motion □Improve endurance □Performance of activities listed above □Return to work □Return to recreation/sports □Other:____________________

Past/current medical history

□Pacemaker	□Cancer	□Diabetes	□Stroke/CVA
□Heart Problems	□Lung Problems	□Seizures	□Bladder/Bowel Problems
□Congestive Heart Failure	□Falls	□Pulmonary Edema	□Peripheral Vascular Disease
□Angina/Chest Pains	□Asthma	□Clinical Depression	□Osteoporosis
□High Blood Pressure	□Low Blood Pressure	□Currently Pregnant	□Osteopenia
□Parkinson's Disease	□Multiple Sclerosis	□Fibromyalgia	□Raynaud's Phenomenon
□Rheumatoid Arthritis	□Current Smoker	□Dementia/Alzheimers	□Other: __________

Past Orthopedic Surgeries

Shoulder Scope	Yes □ L R	Year ______	Shoulder Replacement	Yes □ L R	Year ______
Knee Scope	Yes □ L R	Year ______	Knee Replacement	Yes □ L R	Year ______
Hip Scope	Yes □ L R	Year ______	Hip Replacement	Yes □ L R	Year ______
Wrist	Yes □ L R	Year ______	Ankle/Foot	Yes □ L R	Year ______

Neck - □Fusion □Laminectomy □Other ________ Back - □Fusion □Laminectomy □Other ________

Medications currently taking include □ Pain □Anti-Inflammatory □Muscle Relaxers □Blood Pressure
Do you have an allergy to Latex___Yes □ No □ Adhesive (Tape/Band-Aid)___Yes □ No □

To the best of my knowledge, the information presented above is complete and accurate.

Signature:______________________________ Date ______________

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