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Patient Medical History

Name: _____ DOB: _____ Height: _____ Weight: _____

Referring Doctor _____ Phone _____

Primary Doctor _____ Phone _____

When do you return to doctor who referred you to PT? _____

Injury Description

What is your main complaint that brings you to therapy? _____

_____

When did the injury occur? Date _____

How did the injury occur? _____

Check **all** of those which apply to your **current** condition:

___ Work Related Injury
___ Surgery
___ Injury Recurrence
___ Other _____
___ Sports Injury
___ Aggravation of Pre-Existing Injury
___ Motor Vehicle Accident
___ Fall
___ Causes Unknown
___ Lifting Injury

Describe your level of function **before** injury**: Normal Restricted,** (please specify):

Are your symptoms getting **worse – better – the same** since your injury? (circle one)

What have you been doing to decrease your pain? _____

Have you ever had these symptoms before? ☐ Yes ☐ No **IF so**, When? _____

Please **circle** the tests you have had performed for your injury:

None X-Rays MRI CT Scan Bone Scan Other (Explain) _____

Where were these tests performed? _____ **Results?**_____

Have you had physical therapy for your injury? ☐ Yes ☐ No **IF so,** When? _____

Have you had any injections for your injury? ☐ Yes ☐ No **IF so,** When? _____

What type of non-work/physical activities/sports are you involved in? -_____

Have you had a fall with the past 12 months? ☐ Yes ☐No **If yes,** how many? _____

Is there any other information about your present health that we should know about? _____

Employment Information

Occupation: _____

Primary work duties: _____

Employer: _____ Phone _____ ext. _____

Are you currently working? € Yes € No **IF no**, when did you last work? _____

If yes, are your work duties € Full € Restricted How many hours per week do you work? _____

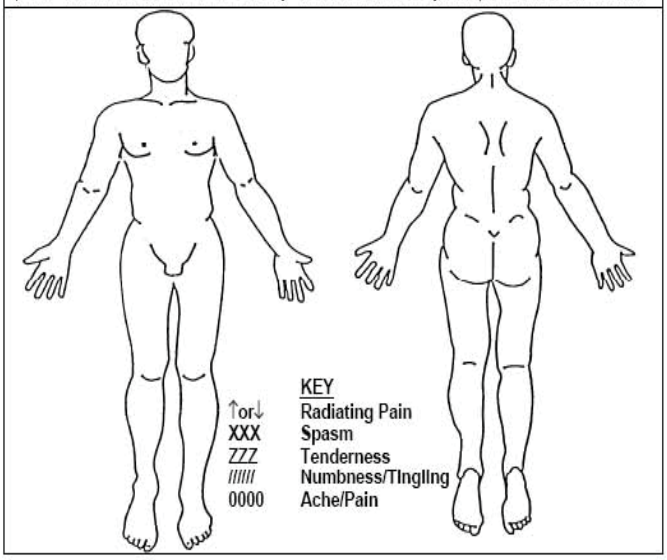
What critical work duties have been most affected by your problem? _____

Have you ever, or are you presently being treated for any of the following?	YES	NO
Diabetes		
Headaches		
Dizzy spells		
Fainting Spells		
Epilepsy		
Stroke		
Pregnancy		
Seizures		
Asthma		
Emphysema		
Osteoporosis		
Back injury		
Arthritis		
Bleeding Disorders		
Fracture		
Cancer		
Pacemaker		
Metal Implants		
Respiratory Problems		
Tuberculosis		
Hepatitis A, B, C		
Heart Trouble		
High Blood Pressure		
Hernia		
Kidney Problems		
Bowel/Bladder Abnormalities		
Liver / Gallbladder Problems		
Smoking		
Sexual Dysfunction		
Skin Abnormalities		
Nausea / Vomiting		
Allergies		
Ringing in your ears		
Rheumatoid Arthritis		
Special Diet guidelines		
Hypoglycemia		

Please check all that may apply. My pain is worse:
in the morning / during the day / at night / constant / with activity / during rest

On a scale of 0 to 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worse _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.



(Complete this diagram at your first appointment)

List all surgeries and dates: _____

_____ _____

_____ _____

_____ _____

List all present medications: _____

_____ _____

_____ _____

_____ _____

How did you hear about us? (circle one)

Internet MD Friend Other

What made you choose Gold Medal Physical Therapy?

_____

To the best of my knowledge, the information I have given is complete and true.

I hereby give my consent to receive therapy services

_____ _____

Patient Signature (Guardian if patient is a minor) Date

_____ _____

Therapist Signature Date

"Personalized, Professional Care"