



Physical Therapy Works

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Social Security #: _____

1. Is a Home Health Agency or Visiting Nursing Association currently seeing you Yes No
2. Have you received any physical or occupational therapy this year? Yes No
3. If yes, where and when was this service provided? _____
4. In your own words, what is the problem that has brought you here for therapy? _____

5. When is the date of onset for this problem? _____
6. Have you had any special tests or treatments done for example x-rays, injections, etc.? Please list.

7. Do you have a past or present medical history of the following?

- | | | |
|-------------------------------------|-------------------------------------|-------------------------------------|
| Yes ___ No ___ Allergies | Yes ___ No ___ Depression | Yes ___ No ___ Multiple Sclerosis |
| Yes ___ No ___ Anemia | Yes ___ No ___ Diabetes | Yes ___ No ___ Osteoporosis |
| Yes ___ No ___ Anxiety | Yes ___ No ___ Dizzy Spells | Yes ___ No ___ Parkinsons |
| Yes ___ No ___ Arthritis | Yes ___ No ___ Emphysema/Bronchitis | Yes ___ No ___ Rheumatoid Arthritis |
| Yes ___ No ___ Asthma | Yes ___ No ___ Fractures | Yes ___ No ___ Seizures |
| Yes ___ No ___ Cancer | Yes ___ No ___ Gallbladder Problems | Yes ___ No ___ Smoke |
| Yes ___ No ___ Cardiac Condition | Yes ___ No ___ Hepatitis | Yes ___ No ___ Speech Problems |
| Yes ___ No ___ Cardiac Pacemaker | Yes ___ No ___ High Blood Pressure | Yes ___ No ___ Strokes |
| Yes ___ No ___ Chemical Dependency | Yes ___ No ___ Incontinence | Yes ___ No ___ Thyroid Disease |
| Yes ___ No ___ Circulation Problems | Yes ___ No ___ Kidney Problems | Yes ___ No ___ Tuberculosis |
| Yes ___ No ___ Currently Pregnant | Yes ___ No ___ Metal Implants | Yes ___ No ___ Vision Problems |

8. Are you allergic to any medications? Yes No
If yes, please list them _____
9. Are you allergic to Latex? Yes No Any skin allergies? Yes No
10. Fall History: Injury as a result of a fall in the past year? Yes No Two or more falls in the last year? Yes No
11. Surgical History: Body Region: _____

Surgery Type: _____ Date (M/Y): _____

12. Current Medications: Drug(s) Dosage _____

Reason for taking _____

Separate list provided Yes No

13. Is this a work related problem? Yes No

If yes, please explain

14. Do you participate in any regular exercises? Yes No

15. What is your occupation? _____

16. Emergency Contact Person _____

Telephone Number: _____

Signature: _____

Date: _____

Therapist Signature: _____

Date: _____

“Let Our Strength Help You Regain Yours”