## PHYSICAL THERAPY MEDICAL HISTORY

PT, OT or Massage ( ) Orthopedist ( ) ER Care ( ) Chiropractor ( ) CT Scan ( ) Other:	Referring Physician:	
DATE OF INJURY: How bid it occur: How would you rate your overall health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor Do you live alone? ( ) Yes ( ) No Have you had any of the following medical or rehabilitative services for this injury? ( ) X-Rays ( ) Drihopeoist ( ) PT, OT or Massage ( ) Orthopeoist ( ) EMG/NCV ( ) PT, OT or Massage ( ) Orthopeoist ( ) ET Care ( ) Chiroperactor ( ) Other: ( ) CT Scan ( ) Other: ( ) Other: ( ) CANCER ( ) Allergies ( ) Feach Incontinence ( ) Allergies ( ) Feach Incontinence ( ) Proper Service ( ) Urinary Incontinence ( ) Hernia ( ) Neurological conditions ( ) Weight Loss or Gain ( ) Dizziness or Fainting ( ) Metal in Body ( ) Anemia ( ) Osteoporosis ( ) Infectious Disease ( ) Depression/Anxiety ( ) Steping Issues/Difficulty ( ) Pregnant, how many months? ( ) Pregnant, how many months? ( ) Mersh Location of Your Pain on the Body diagram.	Family Physician:	S)ONA
How would you rate your overall health? ( ) Excellent ( ) Good ( ) Fair ( ) Poor Do you live alone? ( ) Yes ( ) No Have you had any of the following medical or rehabilitative services for this injury?  ( ) X-Rays ( ) EMG/NCV ) PT, OT or Massage ( ) Orthopedist ) ER Care ( ) Chiroperactor ) CT Scan ( ) Other:  ( ) Oyou have or have you ever had any of the following  ( ) Stroke/Tia ( ) Tobacco Use ) Cancer ( ) Allergies ) Arthritis ( ) Vision or Hearing Issues ) Diabetes ( ) Fecal Incontribence  ( ) Epilepsy/Seizures ( ) Urinary Incontribence ) Respiratory Issues ( ) Metal in Body ) Cardiovascular Issues ( ) Metal in Body ) Cardiovascular Issues ( ) Metal in Body ) Cardiovascular Issues ( ) Infectious Disease ) Depression/Anxiety ( ) Sieping Issues/Difficulty ) Shortness of Breath ( ) Pregnant, how many months?  1. On a scale of 0 – 10, with 0 being no pain and 10 being the worst pain.  Current pain Best pain worst pain  2. Mark the location of your pain on the Body diagram.	Is your visit due to an MVA or W $^{\prime}$	orkman's Comp claim: ( ) Yes ( ) No
DO YOU LIVE ALONE? ( ) YES ( ) NO  HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES FOR THIS INJURY?  ( ) X-RAYS	Date of Injury:	How did it occur:
Have you had any of the following medical or rehabilitative services for this injury?  ( ) X-Rays	How would you rate your overall h	HEALTH? ( ) EXCELLENT ( ) GOOD ( ) FAIR ( ) POOR
( ) X-Rays ( ) EMG/NCV ( ) PT, OT or Massage ( ) Orthopedist ( ) ER Care ( ) Chiropractor ( ) CT Scan ( ) Other:  DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING  ( ) STROKE/TIA ( ) TOBACCO USE ( ) CANCER ( ) ALLERGIES ( ) ARTHRITIS ( ) VISION OR HEARING ISSUES ( ) DIABETES ( ) FECAL INCONTINENCE ( ) EPILEPSY/SEIZURES ( ) HERNIA ( ) WEIGHT LOSS OR GAIN ( ) DIZZINESS OR FAINTING ( ) WEIGHT LOSS OR GAIN ( ) DIZZINESS OR FAINTING ( ) METAL IN BODY ( ) CARDIOVASCULAR ISSUES ( ) ANEMIA ( ) OSTEOPOROSIS ( ) INFECTIOUS DISEASE ( ) SLEEPING ISSUES/DIFFICULTY ( ) SHORTNESS OF BREATH ( ) PREGNANT, HOW MANY MONTHS?  1. ON A SCALE OF 0 - 10, WITH 0 BEING NO PAIN AND 10 BEING THE WORST PAIN.  CURRENT PAIN BEST PAIN WORST PAIN ( ) THE BODY DIAGRAM.	Do you live alone? ( ) Yes ( )	No
PT, OT or Massage () Orthopedist () CHROPRACTOR () CT SCAN () OTHER:  DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING  STROKE/TIA () TOBACCO USE () ARTHRITIS () VISION OR HEARING ISSUES () PECAL INCONTINENCE () EPILEPSY/SEIZURES () HERNIA () METAL IN BODY () CARDIOVASCULAR ISSUES () ANEMIA () OSTEOPOROSIS () INFECTIOUS DISEASE () DEPRESSION/ANXIETY () SLEPPING ISSUES/DIFFICULTY () SHORTHNESS OF BREATH () PREGNANT, HOW MANY MONTHS?  1. ON A SCALE OF O - 10, WITH O BEING NO PAIN AND 10 BEING THE WORST PAIN () CURRENT PAIN () BEST PAIN () WORST PAIN () THE BODY DIAGRAM.	Have you had any of the followin	G MEDICAL OR REHABILITATIVE SERVICES FOR THIS INJURY?
DIZZINESS OR FAINTING CARDIOVASCULAR ISSUES CARDIOVASCULAR CARD	( ) PT, OT OR MASSAGE ( ) ER CARE ( ) CT SCAN  DO YOU HAVE OR HAVE YOU EVER HAD ( ) STROKE/TIA ( ) CANCER ( ) ARTHRITIS ( ) DIABETES ( ) EPILEPSY/SEIZURES ( ) RESPIRATORY ISSUES	( ) Orthopedist ( ) Chiropractor ( ) Other:  O ANY OF THE FOLLOWING  ( ) Tobacco Use ( ) Allergies ( ) Vision or Hearing Issues ( ) Fecal Incontinence ( ) Urinary Incontinence ( ) Hernia
2. Mark the location of your pain on the body diagram.  3. What causes your pain to increase?	<ul> <li>( ) DIZZINESS OR FAINTING</li> <li>( ) CARDIOVASCULAR ISSUES</li> <li>( ) OSTEOPOROSIS</li> <li>( ) DEPRESSION/ANXIETY</li> <li>( ) SHORTNESS OF BREATH</li> <li>1. ON A SCALE OF 0 - 10, WITH</li> </ul>	<ul> <li>( ) Metal in Body</li> <li>( ) Anemia</li> <li>( ) Infectious Disease</li> <li>( ) Sleeping Issues/Difficulty</li> <li>( ) Pregnant, how many months?</li> </ul> 0 being no pain and 10 being the worst pain.
	2. Mark the location of your p	
4. What causes your pain to decrease?	3. What causes your pain to in	icrease?
	4. What causes your pain to de	ECREASE?

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_

## CENTER FOR FUNCTIONAL HEALTH

LIST ALL MEDICATION YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTIONS, OVER-THE-COUNTER, HERBAL AND VITAMIN SUPPLEMENTS.

MEDICATION NAME	START / STOP DATE	DOSAGE	FREQUENCYX/DAY	ROUTE ORAL, NASAL, PATCH, TOPICAL, IV, OTHER	REASON / NOTE
	/				
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	/				
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ATIENT NAME:	DATE:	