PHYSICAL THERAPY MEDICAL HISTORY

Referring Physician: _____

Family Physician: _____

Is your visit due to an MVA or Workman's Comp claim: ( ) Yes ( ) No

Date of Injury: _____ How did 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?

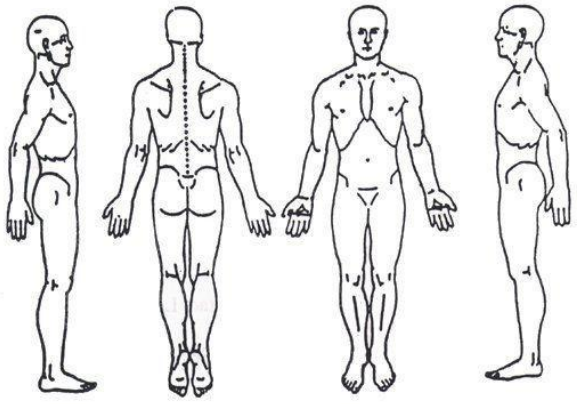
( ) X-Rays
( ) PT, OT or Massage
( ) ER Care
( ) CT Scan
( ) EMG/NCV
( ) Orthopedist
( ) Chiropractor
( ) Other: _____

Do you have or have you ever had any of the following

( ) Stroke/Tia
( ) Cancer
( ) Arthritis
( ) Diabetes
( ) Epilepsy/Seizures
( ) Respiratory Issues
( ) Neurological conditions
( ) Dizziness or Fainting
( ) Cardiovascular Issues
( ) Osteoporosis
( ) Depression/Anxiety
( ) Shortness of Breath
( ) Tobacco Use
( ) Allergies
( ) Vision or Hearing Issues
( ) Fecal Incontinence
( ) Urinary Incontinence
( ) Hernia
( ) Weight Loss or Gain
( ) Metal in Body
( ) Anemia
( ) Infectious Disease
( ) Sleeping Issues/Difficulty
( ) 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.



3. What causes your pain to increase? _____

4. What causes your pain to decrease? _____

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**	**FREQUENCY** ____ x/day	**ROUTE** oral, nasal, patch, topical, iv, other	**REASON / NOTE**
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PATIENT NAME: _____ DATE: _____