PATIENT MEDICAL HISTORY

Name: _____Age: ____ Date of next Doctor's appointment: _____
Are you currently receiving any type of home care? ____Are you pregnant?___
Are you currently receiving therapy anywhere else? _____
Have you had P.T./O.T./Speech therapy anywhere else THIS YEAR? _____
Are you presently working? _____ If Yes: __Light/moderate duty __Regular duty
Which area is the problem?_____
How did this problem begin? Briefly describe: _____

_____
Date when injury or problem first occurred: _____
Was the onset ___Gradual or ___Sudden?
Have you been hospitalized for this problem? ____If yes, when? _____
Have you had any testing, x-ray, MRI, CAT scan, etc.? If yes, please specify.

_____
Are you currently seeing any other Doctors? If so please list. _____

_____
Please list any hospitalizations: _____
Have you ever been diagnosed with or do you have the following? Check if yes:

__ Seizures	**__High Blood Pressure**	**__Elevated Cholesterol**
__Cancer	**__Respiratory Problems**	**__Diabetes**
__Tuberculosis	**__Seizures**	**__Osteoporosis**
__Hepatitis	**__Rheumatoid Arthritis**	**__Pace Maker**
__Kidney Disease	**__Other Arthritic conditions**	**__History of heart disease**
__Depression	**__Chemical Dependency**	**__Ortho Surgery**
__Fibromyalgia	**__Spinal Stenosis**	**__Do you smoke?**

Other _____ Allergies? (Drug/other)_____
Have you ever had a fracture or dislocation? If yes, please specify. _____
Do you have any metal or plastic in your body? If yes, Please specify._____
PLEASE LIST ALL MEDICATIONS AND RECENT INJECTIONS: _____

_____
Who can we thank for referring you? _____
PATIENT SIGNATURE: _____Date: _____
REVIEWED BY THERAPIST:_____Date :_____