Care Medical Group

PHYSICAL THERAPY MEDICAL HISTORY

1.

____
Last Name

______________________________ ________
First Name M.I.

2. Phone:______________________________

3. Date of Birth: Month ☐☐ Day ☐☐ Year ☐☐☐☐

4. Sex: ☐ Male ☐ Female

5. Are you: ☐ Right-handed ☐ Left-handed

6. Who referred you to the physical therapist:

____

7. Employment/Work (Job/School/Play)

☐ Working full-time outside of home
☐ Working part-time outside of home
☐ Working full-time from home
☐ Working part-time from home
☐ Homemaker
☐ Student
☐ Retired
☐ Unemployed

Occupation: ______________________________

8. SOCIAL/HEALTH HABITS

Smoking

Smoke tobacco? ☐ No, never smoked ☐ Yes
☐ Cigarettes: # of packs per day ____________
☐ Cigars / Pipes # per day ____________________

Smoked in past? ☐ Yes Year quit: ☐☐☐☐

Exercise

Do you exercise beyond normal daily activities and chores?

☐ Yes. Describe:______________________________

On average, how many days per week do you exercise or do physical activity?______________________
For how many min. on an average day?____________

☐ No

9. FAMILY HISTORY (Indicate whether mother/father, brother/sister, aunt/uncle, grandmother/grandfather, and age of onset if known)

Heart disease:______________________________
Hypertension:______________________________
Stroke:______________________________
Diabetes:______________________________
Cancer:______________________________
Arthritis:______________________________
Osteoporosis:______________________________
Other:______________________________

10. MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

☐ Allergies **(Latex)**
☐ Multiple sclerosis
☐ Muscular dystrophy
☐ Osteoporosis
☐ Blood disorders
☐ Heart problems
☐ High blood pressure
☐ Lung problems
☐ Kidney problems
☐ Diabetes/ high blood sugar
☐ Low blood sugar/ hypoglycemia
☐ Arthritis
☐ Broken Bones/fractures
☐ Parkinson disease
☐ Seizures/epilepsy
☐ Circulation/vascular problems
☐ Thyroid problems
☐ Cancer
☐ Infectious disease (eg, tuberculosis, hepatitis
☐ Stroke
☐ Repeated infections
☐ Depression
☐ Head injury
☐ Other:________________

Within the past year, have you had any of the following symptoms? (Check all that apply.)

☐ Chest pain
☐ Heart palpitations
☐ Cough
☐ Shortness of breath
☐ Dizziness or blackouts
☐ Coordination problems
☐ Weakness in arms or legs
☐ Difficulty walking
☐ Joint pain or swelling
☐ Difficulty sleeping
☐ Loss of appetite
☐ Nausea/vomiting
☐ Weight loss/gain
☐ Fever/chills/sweats
☐ Headaches
☐ Loss of balance
☐ Pain at night
☐ Other:________________

Have you ever had surgery? ☐ Yes ☐ No

If yes, please describe, and include dates:

	Month	Year
______________________________	☐☐	☐☐☐☐
______________________________	☐☐	☐☐☐☐

(Please see other side)

For men only: Have you been diagnosed with prostate disease?
☐ Yes ☐ No

For women only:
Have you been diagnosed with:
Trouble with your period? ☐ Yes ☐ No
Pregnant or think that you might be pregnant? ☐ Yes ☐ No

11. CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

Describe the problems(s) for which you seek physical therapy:___
___

	Month	Year
When did the problem(s) begin?	☐☐	☐☐☐☐

What happened?___
___

Have you ever had these problem(s) before?
☐ Yes
What did you do for the problem:___
Did the problem get better?
☐ Yes ☐ No
About how long did the problem last?___
☐ No
How are you taking care of the problem(s) now?___
What makes the problem(s) better?___
What makes the problem(s) worse?___
What are your goals for physical therapy?___

Are you seeing anyone else for the problem(s)?
☐ Acupuncturist
☐ Cardiologist
☐ Chiropractor
☐ Dentist
☐ Family practitioner
☐ Internist
☐ Massage therapist
☐ Neurologist
☐ Obstetrician
☐ Occupational therapist
☐ Orthopedist
☐ Osteopath
☐ Pediatrician
☐ Podiatrist
☐ Primary care physician
☐ Rheumatologist
☐ Other___

12. FUNCTIONAL STATUS/ACTIVITY LEVEL

☐ Difficulty with locomotion/movement:
☐ Bed mobility
☐ Transfers (such as moving from bed to chair)
☐ Gait (walking)
☐On level ☐On ramps
☐On stairs ☐On uneven terrain
☐ Difficulty with self-care (such as bathing, dressing, eating)
☐ Difficulty with home management (such as household chores, shopping, driving, care of dependents).
☐ Difficulty with community and work activities/integration
☐ Work/school
☐ Recreation or play activity

13. MEDICATIONS

Do you take any prescription medications? ☐Yes ☐No
If yes, please list:___
___

Check any nonprescription medications that you take.
☐ Advil/Aleve
☐ Antacids
☐ Ibuprofen/ Naproxen
☐ Antihistamines
☐ Aspirin
☐ Decongestants
☐ Herbal supplements
☐ Tylenol
☐ Other___

Have you taken any medications previously for the condition for which you are seeing the physical therapist?
☐ No ☐ Yes. If yes, please list:___

14. OTHER CLINICAL TESTS

Within the last year, have you had any of the following tests? (Check all that apply.)
☐ Arthroscopy
☐ Biopsy
☐ Blood tests
☐ Bone scan
☐ CT scan
☐ Spinal tap
☐ Echocardiogram
☐ EKG
☐ EMG
☐ MRI
☐ Myelogram
☐ NCV (nerve conduction velocity)
☐ Doppler ultrasound
☐ Pulmonary function test
☐ X-rays
☐ Stress test (eg. Treadmill, bicycle)
☐ Other:___