

SportsCare Physical Therapy, PC
MEDICAL/PHYSICAL HISTORY FORM

Patient _____ **Age** _____ **Date** _____

DO YOU HAVE A HISTORY OF:

- | | | |
|--|---|--|
| <input type="checkbox"/> Fainting Spell | <input type="checkbox"/> Are you thirsty often? | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Do you have shortness of breath? | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pain or tightness in the chest? | <input type="checkbox"/> Bruise easily |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High or low blood sugar | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High or low blood pressure | <input type="checkbox"/> Other |
| <input type="checkbox"/> Circulatory condition | <input type="checkbox"/> Kidney or liver disease | |

LIST DOCTORS YOU HAVE SEEN FOR THE ABOVE CONDITIONS:

What is the diagnosis the doctor sent you to physical therapy for? _____

Have you been treated for this condition before? Yes/No

Have you been treated in physical therapy before? If yes, for what condition? _____

The onset of the present condition began on what date? _____

Was the onset of this condition caused from trauma? If yes, explain _____

Was the onset of the present condition an exacerbation of a previous condition? Yes/No

Was the onset of the present condition of unknown origin? Yes/No

Did you have any special tests such as x-rays, MRI, CT scans, EMG's? _____

If you had special tests, what were the results? _____

Did you receive an operation for the present condition? Yes/No

If you received an operation for this condition, what was the name of the procedure and the date it was performed? _____

What is your chief complaint at the present time? _____

Have your symptoms remained the same, increased or decreased?

How would you grade your pain level if 1 was the least and 10 were the worst? ___/10

Describe what causes your pain, i.e. movements, activities, static positions, morning pain, evening pain: _____

How would you grade your activity level? High Moderate Low

Are you working? Yes/No If not, do you have a job to return to? Yes/No

What is your occupation? _____

Please list the medication you are taking for the present condition? _____

Has the medication prescribed helped/not helped, decrease pain/swelling? _____