Medical History

FULL NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

PLEASE MARK THE FOLLOWING IF YOU HAVE HAD:

____ ALLERGIES
____ ASTHMA
____ CLOT/EMBOLI
____ CELLULITIS
____ CORONARY HEART DISEASE
____ ENERGY LOSS
____ GULLAIN-BARRE
____ HEART DISEASE
____ LIPEDEMA
____ MULTIPLE SCLEROSIS
____ OXYGEN DEEPENDENCY
____ RHEUMATOID ARTHRITIS
____ SLEEPING PROBLEMS
____ TORTICOLLIS
____ VISION DIFFICULTIES
____ CANCER

____ AMPUTATION
____ ATAXIA
____ BOWEL/BLADDER
____ CEREBRAL PALSY
____ DIZZINESS OR FAINTNESS
____ EPILEPSY/SEIZURES
____ HEADACHE, SEVERE
____ HERNIA
____ LOW BLOOD PRESSURE
____ NEUROLOGICAL ISSUES
____ PACEMAKER
____ SCIATICA
____ SPINAL STENOSIS
____ VARICOSE VEINS
____ WEAKNESS
____ DIABETES, TYPE 1

____ ANEMIA
____ BELL'S PALSY
____ BRONCHITIS
____ CONCUSSION
____ DRINK ALCOHOL
____ EPSTEIN-BARR
____ HEARING DIFFICULTIES
____ HIGH BLOOD PRESSURE
____ LYMPHEDEMA
____ OSTEOARTHRITIS
____ PARKINSON'S DISEASE
____ SHORTNESS OF BREATH
____ STROKE/TIA
____ VASCULITIS
____ WEIGHT LOSS
____DIABETES, TYPE 2

____ ANGINA
____ BLOOD
____ CARPAL TUNNEL
____ COPD
____ EMPHYSEMA
____ GOUT
____ HEART ATTACK
____ KIDNEY DISEASE
____ MASTECTOMY
____ OSTEOPOROSIS
____ PNEUMONIA
____ SLEEP APNEA
____ THYROID
____ VERTIGO/BALANCE
____ WOMEN'S HEATLH

____ I HAVE RECEIVED PT OR OT TREATMENT AT HOME
____ I LIVE ALONE
____ MY HOME HAS STAIRS
____ I USE A CANE
____OTHER IMPORTANT ISSUES
____ I AM A CAREGIVER FOR SOMEONE ELSE
____I USE A WHEELCHAIR
____ OTHER SURGERY
____ I USE A WALKER

FALLS IN THE LAST YEAR: ____ 0 ____ 1 ____ 2____ 3 ____ 4 ____ 5 ____ 6 OR MORE

JOINT REPLACEMENT(S): _____

PINS/ METAL IMPLANT(S): _____

LOCATION OF ARTHRITIS: _____

LOCATION OF NUMBNESS/TINGLING/NEUROPATHY: _____

HOW OFTEN DO YOU EXERCISE?

___ NEVER ___ 1X PER WEEK ___ 2X PER WEEK ___ 3X PER WEEK ___ 4X+ PER WEEK

DOES YOUR ROUTINE OR WORK AGGRAVATE YOUR INJURY/CONDITION?

___ NO ___ ONCE WEEKLY ___ BIWEEKLY ___ DAILY ___ UNABLE TO PARTICIPATE IN NORMAL ROUTINE

DOES YOUR INJURY/CONDITION IMPACT YOUR ABILITY TO DO YOUR JOB?

____ RETIRED ____ PREVENTS ME FROM WORKING ____ I CAN ONLY WORK PART-TIME

____ I WORK WITH MINOR DIFFICULTY ____ I WORK WITH GREAT DIFFICULTY

____ DOES NOT IMPACT MY ABILITY TO WORK

DOES YOUR INJURY/CONDITION IMPACT YOUR ABILITY TO ATTEND SCHOOL?

____ N/A ____ PREVENTS ME FROM ATTENDING ____ IN SCHOO, BIG IMPACT

____ IN SCHOO, MINOR IMPACT ____ SCHOOL IS NORMAL, CAN'T PARTICIPATE IN SPORTS

____ SCHOOL IS NORMAL, NO IMPACT

DO YOU USE TOBACCO? ____NO ____SMOKE ____CHEW ____SNUFF

HAVE YOU RECEIVED TOBACCO CESSATION COUNSELING? ____YES ____NO

HAVE YOU OFTEN BEEN BOTHERED BY FEELING DOWN, DEPRESSED OR HOPELESS? ____YES ____ NO

HAVE YOU BEEN BOTHERED BY HAVING LITTLE INTEREST OR PLEASURE IN DOING THINGS? ____ YES ____ NO

ARE YOU PREGNANT? ____YES ____NO

ARE YOU ALLERGIC TO ANY MEDICATIONS, METALS, LATEX? **YES / NO.** IF YES, PLEASE LIST MEDICATIONS.
_____

PLEASE LIST ANY MAJOR SURGERIES/ HOSPITALIZATIONS AND DATE:
_____
_____

HAVE ANY OF THESE DIAGNOSTIC TESTS HAVE BEEN PERFORMED?

____ X-RAYS DATE:_____ RESULTS:_____

____ MRI DATE:_____ RESULTS:_____

____ CAT SCAN DATE:_____ RESULTS:_____

____ EMG/NCV DATE:_____ RESULTS:_____

HAVE YOU BEEN TREATED BY A PHYSICAL THERAPIST? ____YES ____ NO

CHIROPRACTOR? ____YES ____ NO MASSAGE THERAPIST? ____YES ____ NO

IF YES, APPROXIMATE DATE: _____

WHAT WERE YOU TREATED FOR? _____

DATE OF ONSET OF PAIN? _____ WAS IT DUE TO AN INJURY? ____ YES ____ NO

IS THIS PROBLEM WORK RELATED? ____ YES ____ NO MOTOR VEHICLE ACCIDENT ____ YES ____ NO

PLEASE DESCRIBE YOUR PROBLEM: _____
_____

PLEASE CHECK THE FOLLOWING WHICH BEST DESCRIBES YOUR PAIN:

____ ACHING ____BURNING ____CONSTANT ____ CRAMPING ____ DEEP ____ DULL
____ HEAVY ____NUMB ____ STABBING ____ THROBBING ____ VARIABLE ____ WEAK
____ PINS/NEEDLES

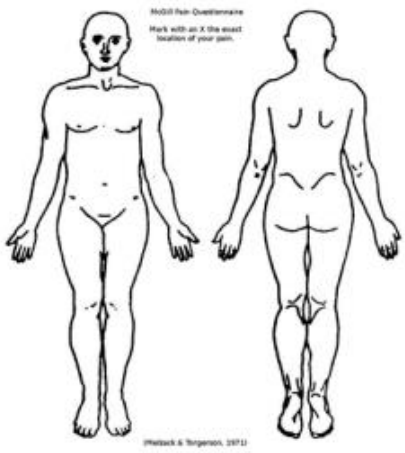
RATE YOUR PAIN WHEN THE INJURY FIRST OCCURRED: (NO PAIN) **0 1 2 3 4 5 6 7 8 9 10** (WORST PAIN IMAGINABLE)

RATE YOUR PAIN CURRENT/ RECENT PAIN/ DISCOMFORT AT WORST FROM 0-10: ____ AT ITS BEST FROM 0-10: ____

PAIN IS AGGRAVATED BY: ____ CARRYING ITEMS ____ LIFTING HEAVY WEIGHT ____ LIFTING ANYTHING
____ BENDING ____ CLIMBING STAIRS ____ DRESSING/GROOMING ____ GETTING OUT OF BED
____ COOKING ____ REACHING BACK ____ RAISING ARMS OVER HEAD ____ LOOKING UP / DOWN
____ LYING FLAT ____ PULLING ____ TWISTING ____ WALKING ____ SITTING

PAIN EASED BY: ____ ICE ____ HEAT ____MEDICATION ____ LYING FLAT
____ STRETCHING ____ EXERCISE ____REST ____ NOTHING

PLEASE INDICATE THE AREA OF PAIN



I, THE UNDERSIGNED, STATE THAT I HAVE ANSWERED THIS QUESTIONAIRE TO THE BEST OF MY KNOWLEDGE.

_____
SIGNATURE (parent/guardian if under 18)

_____
DATE