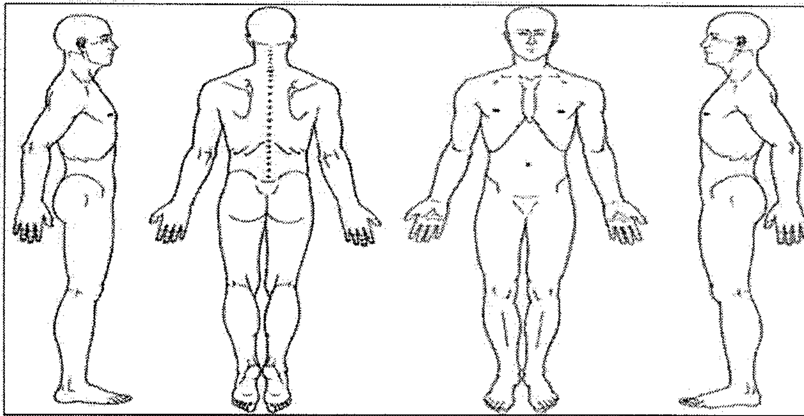
Medical History

Please mark on the diagram where you experience symptoms.



KEY
+=Sharp Pain
#= Dull Pain/Aching
>=Numbness
^=Tingling
x= Other:_________

1. What body part(s) are you currently seeking physical therapy treatment for? ______________________

2. What is your main limitation due to your injury/condition? ______________________________________

3. When did your current symptoms begin? (Please give your best estimate of specific date): ___________

4. Have you fallen in the past year? ____

5. Please list any surgeries you have had and approximate dates (circle if for your current injury):

____

6. Please list any medications you are taking (prescription, over the counter and vitamins/minerals):

____

7. Are you allergic to any medications? □ Yes □ No List Medications:______________________________

Please circle any of the following services you have had for this Injury/ Episode:	Emergency Room Care Massage Therapy Acupuncture Injection	CT Scan X-Rays MRI Bone Scan	Physical Therapy Chiropractic Occupational Therapy

Please circle if you have a history of the following:

Blood Clot/ Emboli	Parkinson's Disease	Asthma, Bronchitis, or Emphysema
Varicose Veins	Multiple Sclerosis	Severe or Frequent Headaches
Epilepsy/ Seizures	Cancer:__________	Dizziness or Fainting
Allergies	Arthritis	Fever/Chills/Sweats
Thyroid Disease or Goiter	Osteoporosis	Pain at night
Any Pins or Metal Implants	Hernia	Bowel or Bladder Problems
Anemia	Stroke	Difficulty Swallowing
Neck Injury or Back injury	Gout	Shortness of Breath/ Chest Pain
Infectious Disease	High Blood Pressure	Congestive Heart Failure
Unexplained Weight Gain	Are Pregnant	Coronary Heart Disease or Angina
Weight Loss/ Energy Loss	Emotional Problems	Heart Attack or Heart Surgery(date) :______
Weakness	Diabetes	Use Tobacco
Visual or Hearing Difficulties	Latex Allergy	Other:____________

Any addition information which may help with your care?

____

Patient/Guardian Signature: ________________________________ **Date**__________________

Medicare Questionnaire

Medicare requires this form to be completed by all Medicare patients. Please read each of the following and respond ONLY to those that apply to your current situation.

Patient Name: ______________________________ HIC # ________________

1. If you have received home healthcare in the past 60 days, please provide us with the name and telephone number of the home health agency.

   ____

2. If you are entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program, please provide the name, address, and phone number for that program. ______________________________________

   ____

3. Was your illness or injury due to any of the following:
   Work   Auto Accident   Accident on property other than your own, i.e. store, restaurant, etc.
   Date of your Accident if one of the above: ___/___/___
   Details of your accident: ______________________________
   ____
   ____
   Liability Insurance Information for the above accident: ________________
   ____
   Medicare requires us to file with the above liability insurance first.
4. Do you feel that you have the right to be compensated by a party who may have caused the injury or illness ?   Yes   No
5. If Yes, do you intend to file a liability claim of lawsuit in connection with this injury of
   illness ?   Yes   No If Yes, pleas provide your attorney's name, address and phone: ______________________________________
6. If you have received a kidney transplant or are receiving dialysis for End Stage Renal Disease, please give the date of the transplant or start of dialysis : ___/___/___
   If the date is less than 18 months ago, are you currently covered under group insurance provided by your employer or a family member's employer ?   Yes   No
7. If none of these apply to you and your Medicare coverage is due to age or disability. Do you have group health coverage through your employer or a family member's employer ?   Yes   No

If you answered YES to questions #6 or #7 above, please provide your group health insurance information:

Name: ______________________________________
Address: ____________________________________
Telephone: __________________________________
Employer's Name: _____________________________

Patient Signature: ______________________________   Date: ___/___/___

Clinic Witness: ______________________________

Patient Name:

Please list all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary supplements

Medication Name	Dosage	Frequency	How taken (oral, injection, etc.)