PROactive
PHYSICAL THERAPY SPECIALISTS

MEDICAL HISTORY FORM

PATIENT NAME: ____ Acct#: ____________________

Please check if you have been diagnosed with any of the following conditions:

_____Diabetes(I/II)	_____Heart Disease	_____High Blood Pressure	_____Cancer
_____Pacemaker	_____Stroke (TIA or CVA)	_____Seizures	_____Metal Implants
_____Back Pain	_____Circulation problems	_____Osteoporosis	_____Stomach ulcers
_____Broken bones	_____Respiratory Problems	_____Depression	_____Asthma
_____Blood Clots	_____Rheumatoid Arthritis	_____Thyroid Problems	_____Kidney problems

_____Infectious Diseases (HIV, Hepatitis, TB, etc.) ____

_____Other: ____

Surgical History: ____

Have you recently noted? Check all that apply:

_____Nausea/Vomiting	_____Dizziness spells	_____Pain at night	_____Currently pregnant
_____Unusual weakness	_____Visual problems	_____Heart Palpitations	_____Hearing problems
_____Bleeding	_____Difficulty walking	_____Joint pain or swelling	_____Fever/chills/sweats
_____Chest Pain	_____Shortness of breath	_____Incontinence	_____Productive/Chronic Cough
_____Difficulty sleeping	_____Loss of Appetite	_____Unexplained weight changes	_____Fatigue or myalgia

Have you recently traveled out of the country? ☐ **Yes** ☐ **No**

Have you had direct prolonged contact with someone with confirmed case of coronavirus? ☐ **Yes** ☐ **No**

How many times have you fallen in the past 12 months? _________ Did it results in an injury? ☐ Yes ☐ No

During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

Please list all, both prescribed and over the counter medications you are currently taking, include name, dosage, frequency, route taken:

____

____

____

Sex: ☐ Male ☐ Female **Height:** ______________ **Weight:** _______________

Are you: ☐ Right handed ☐ Left handed

Do you have any allergies? ☐ Yes ☐ No If yes, please list: ____

With whom do you live:

☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other ______________________________

Where do you live:

☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other__________________

Does your home have:

☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain

Please explain: ____

Employment/Work (Job/School/Play):

☐ Working: ☐ Full time ☐ Part time ☐ Retired ☐ Unemployed ☐ Occupation: ______________________

PATIENT NAME: ____

General Health Status, Please rate your health; ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Date of onset of current symptoms/injury: Month ________ Day ________ Year ___________

Describe the problem(s) for which you seek therapy: ____

____

Explain how problem(s) occurred: ____

____

How are you taking care of the problem(s) now? ____

What makes the problem(s) better? ____

What makes the problem(s) worse? ____

What functions could you perform before, that now you are unable to do? ____

____

What are your goals for therapy? ____

Have you ever had the problem(s) before? ____

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications etc.____

Have you received X-rays, MRI, CT scan, Bone Scan, etc. for this problem? If so, what were the results

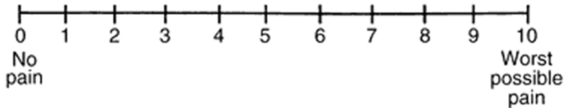
____

Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No

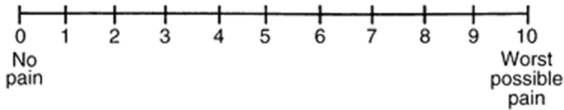
If yes, please tell us what it is: ____

Pain Rating:
If you have pain, what is your pain level? Circle

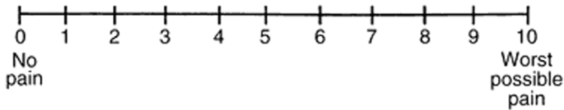
CURRENT Pain



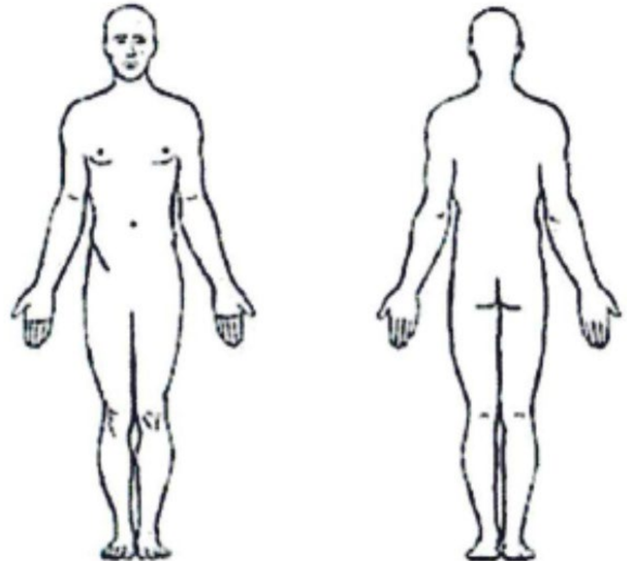
Pain level at **BEST**



Pain level at **WORST**



Please mark the location of pain with an "X"



To the best of my knowledge the above information is accurate and complete.

Signature: ____ **Date:** ______________________

Thank you for completing this questionnaire. It will allow us to better serve your needs.

Therapist signature: ____ Date: ______________________