**ALLIED PHYSICAL THERAPY**

**PAST MEDICAL HISTORY**

**NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF BIRTH\_\_\_/\_\_\_/\_\_\_\_ TODAYS DATE \_\_\_/\_\_\_/\_\_\_\_**

**PRIMARY CARE PROVIDER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SPECIALIST\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WHAT ARE WE SEEING YOU FOR?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**DATE OF INJURY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE OF SURGERY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HEIGHT**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **WEIGHT** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **AGE** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAIN: Circle the phrase that best describes your current level of pain.**

No Pain (0) Slight Pain (1) Mild Pain (2) Moderate Pain(3) Severe Pain (4) Extreme Pain (5) Worst Pain Imaginable (6)

**LOCATION OF PAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WHEN DID IT START?\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HAVE YOU SEEN ANY OTHER MEDICAL PROVIDERS FOR THIS PROBLEM?** YES / NO

If YES: Primary Care Provider / PT / OT / Chiropractor / Other\_\_\_\_\_\_\_\_\_\_\_\_\_

**IS THIS WORK RELATED?** YES / NO **MOTOR VEHICLE ACCIDENT?** YES / NO

On a separate sheet, please describe the details of your accident.

**PREVIOUS PHYSICAL THERAPY:** YES / NO **If YES, Where**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **When**\_\_\_\_\_\_\_\_\_\_\_\_\_

**RELATED SURGERY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

**OTHER SURGERIES**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

**HAVE YOU FALLEN IN THE PAST 12 MONTHS?** YES/NO If yes, did you injure yourself? YES/NO If yes, How did you fall?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:**

\_\_\_ALLERGY \_\_\_HEMOPHILIA \_\_\_OSTEOPOROSIS

\_\_\_ANEMIA \_\_\_HEPATITIS \_\_\_PACEMAKER

\_\_\_CANCER \_\_\_HERNIA \_\_\_PREGNANCY

\_\_\_ARRHYTHMIA \_\_\_HIGH BLOOD PRESSURE \_\_\_CLAUSTROPHOBIA

\_\_\_HIV/AIDS \_\_\_RECENT FRACTURES \_\_\_DIABETES \_\_\_HYPOGLYCEMIA \_\_\_RECENT WEIGHT LOSS \_\_\_DIZZINESS \_\_\_INCONTINENCE \_\_\_ RHEUMATOID ARTHRITIS \_\_\_FEVER \_\_\_KIDNEY DISEASE \_\_\_SEIZURES \_\_\_GERD \_\_\_LUNG PROBLEMS \_\_\_SKIN SENSITIVITIES \_\_\_HEADACHES \_\_\_METAL IMPLANTS \_\_\_STROKE \_\_\_HEART ATTACK/FAILURE \_\_\_NERVOUS DISORDER \_\_\_THROMBOPHLEBITIS \_\_\_HEART DISEASE \_\_\_OPEN WOUNDS \_\_\_HEART MURMUR \_\_\_OSTEO-ARTHRITIS

Have you ever had any serious illness not listed above? \_\_\_\_\_YES \_\_\_\_\_NO

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS PRESENTLY TAKING** (Please attach a separate sheet if necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or to the patient’s) health. It is my responsibility to inform Allied Physical Therapy of any changes in my medical status.

**SIGNATURE OF PATIENT,**

**PARENT, OR GUARDIAN**: **DATE:**