

**ALLIED PHYSICAL THERAPY
PAST MEDICAL HISTORY**

NAME _____ DATE OF BIRTH ___/___/___ TODAYS DATE ___/___/___

PRIMARY CARE PROVIDER _____ SPECIALIST _____

WHAT ARE WE SEEING YOU FOR? _____

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?

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

<input type="checkbox"/> ALLERGY	<input type="checkbox"/> HEMOPHILIA	<input type="checkbox"/> OSTEOPOROSIS	
<input type="checkbox"/> ANEMIA	<input type="checkbox"/> HEPATITIS	<input type="checkbox"/> PACEMAKER	
<input type="checkbox"/> CANCER	<input type="checkbox"/> HERNIA	<input type="checkbox"/> PREGNANCY	
<input type="checkbox"/> ARRHYTHMIA	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> CLAUSTROPHOBIA	
<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> RECENT FRACTURES	<input type="checkbox"/> DIABETES	
<input type="checkbox"/> HYPOGLYCEMIA	<input type="checkbox"/> RECENT WEIGHT LOSS	<input type="checkbox"/> DIZZINESS	
<input type="checkbox"/> INCONTINENCE	<input type="checkbox"/> RHEUMATOID ARTHRITIS	<input type="checkbox"/> FEVER	
<input type="checkbox"/> KIDNEY DISEASE	<input type="checkbox"/> SEIZURES	<input type="checkbox"/> GERD	
<input type="checkbox"/> PROBLEMS	<input type="checkbox"/> SKIN SENSITIVITIES	<input type="checkbox"/> HEADACHES	<input type="checkbox"/> LUNG
<input type="checkbox"/> IMPLANTS	<input type="checkbox"/> STROKE	<input type="checkbox"/> HEART ATTACK/FAILURE	<input type="checkbox"/> METAL
<input type="checkbox"/> DISORDER	<input type="checkbox"/> THROMBOPHLEBITIS	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> NERVOUS
<input type="checkbox"/> HEART MURMUR	<input type="checkbox"/> OSTEO-ARTHRITIS	<input type="checkbox"/> OPEN WOUNDS	

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). _____

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: