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# Patient Medical History

Patient Name _____ Height _____ Weight _____

Type of Injury/Condition _____ Date of Injury/Onset _____

(If Applicable) Type of Surgery/Procedure _____ Date of Surgery _____

**Please describe your physical limitations as a result of this injury/surgery:** _____

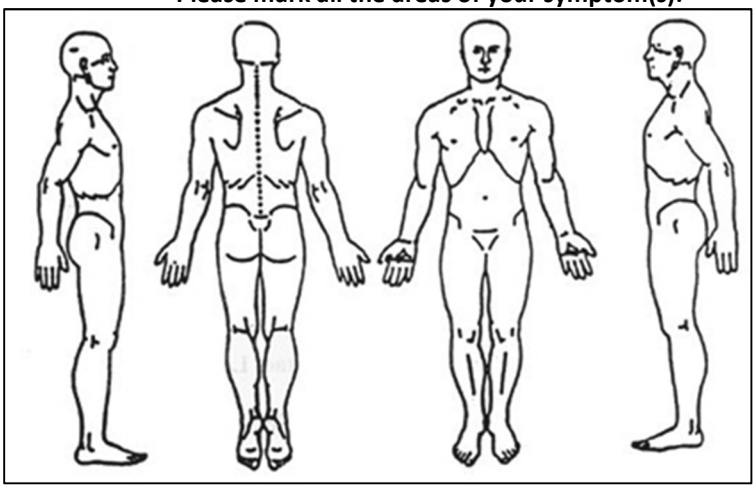
**Please describe any activities or movements that aggravate your symptoms:** _____

**Please describe any treatments, movements or self-care that decrease your symptoms:** _____

**Please list any previous injury, conditions or surgeries:** _____

**Have you had any of the following diagnostic test in relating to this injury?** *(mark all that apply)*
☐ X-Ray ☐ MRI ☐ CT Scan ☐ Doppler ☐ Ultrasound ☐ Other

**Please mark all the areas of your symptom(s):**



**Which of the following describes your pain:**
*(mark all that apply)* ☐ Sharp ☐ Achy ☐ Burning
☐ Tingling ☐ Numbness ☐ Other: _____

**Please rate your pain:** *(0= none, 5=moderate, 10= Severe)*

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| At present: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At best: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| At worst: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

**Are you currently taking ANY medications?** ☐ YES ☐ NO
Please list ALL medication/dosages: _____

**Fall History:** Is your injury the result of a fall? ☐ Yes ☐ No Have you fallen twice or more in the past year? ☐ Yes ☐ No
Dates of falls: _____

**Health Habits and Lifestyle:**
Do you eat a well-balanced diet? ☐Yes ☐No Do you drink water regularly? ☐Yes ☐No # of glasses each day: _____
Do you smoke? ☐Yes ☐No Daily amount: _____ For how long? _____
Do you drink alcohol? ☐Yes ☐No #/day? _____ Days/week? _____
Do you exercise regularly? ☐Yes ☐No How often? _____ Type / program? _____
Do you have any hobbies/leisure activities: ☐Yes ☐No Type: _____

Patient Name _____ Date _____

**Medical History:** have you been diagnosed with any of the following conditions:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Allergies | Y | N | Diabetes | Y | N | Metal implants | Y | N |
| Anemia | Y | N | Dizziness/ringing in ears/vertigo | Y | N | Multiple Sclerosis | Y | N |
| Anxiety | Y | N | Emphysema/Chronic Bronchitis | Y | N | Neurological disorder | Y | N |
| Arthritis | Y | N | Fibromyalgia/Chronic Fatigue | Y | N | Numbness/tingling | Y | N |
| Asthma | Y | N | Fractures | Y | N | Osteoporosis/Osteopenia | Y | N |
| Bladder/Bowel problems | Y | N | Gastrointestinal Problems | Y | N | Pain Syndromes/CRPS | Y | N |
| Cancer | Y | N | Gallbladder problems | Y | N | Parkinson's | Y | N |
| Cardiac Disease/Conditions | Y | N | Headache/Migraines | Y | N | Seizures | Y | N |
| Cardiac pacemaker/ | Y | N | Hepatitis | Y | N | Speech problems | Y | N |
| Defibrillator | Y | N | Hernia | Y | N | Strokes | Y | N |
| Circulation problems | Y | N | High blood pressure | Y | N | Thyroid problems | Y | N |
| Currently pregnant | Y | N | Incontinence | Y | N | Vision problems | Y | N |
| Depression | Y | N | Kidney problems | Y | N | | | |

Please describe in detail any diagnosis marked "Y"**:** _____

_____

_____

Have you suffered from any illness not listed here? ☐ Yes ☐ No If yes, please explain: _____

## Treatment History:

Have you been treated for this condition before? By whom? _____

Was it helpful? ☐Yes ☐No Please explain: _____

What are your goals for Physical Therapy? _____

What do you hope to get out of your treatment? _____

What are your current physical or fitness goals? _____

Please list any important dates (such as return to sport/big performance/games coming up that you want to be ready to participate):

_____

Is there anything else you would like to include or ask your physical therapist? _____

_____

## CONSENT FOR CARE AND TREATMENT:

I, _____ hereby agree and give my consent for Sports & Performance Physical Therapy to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition. _____ (initial)

FOR MINORS ONLY: CONSENT FOR CARE: As parent and/or legal guardian, I authorize Sports & Performance Physical Therapy to treat the minor patient named in the attached forms while I am not present. _____ (parent/guardian initial)

By signing below, I agree that all of the above information is correct, and that I authorize Sports & Performance Physical Therapy to provide me with therapy services and to furnish my physician, insurance company or attorney information concerning my injury and treatment.

Patient Signature (Parent/Guardian if necessary): _____ Date: _____