

**MEDICAL HISTORY**

Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Injury/Surgery \_\_\_\_\_

1. Why were you referred to physical therapy? \_\_\_\_\_

2. Please describe how your injury occurred: \_\_\_\_\_  
\_\_\_\_\_

3. Have you previously been treated for this condition? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what treatment did you receive? \_\_\_\_\_  
Where? \_\_\_\_\_

4. Please list any special exams/tests/procedures you have had related to this injury: \_\_\_\_\_  
\_\_\_\_\_

5. Do you have a history of: (check all that apply)  
\_\_\_\_\_ Heart condition \_\_\_\_\_ Diabetes \_\_\_\_\_ Seizures  
\_\_\_\_\_ High blood pressure \_\_\_\_\_ Stroke \_\_\_\_\_ Cancer  
\_\_\_\_\_ Respiratory disorders \_\_\_\_\_ Dizziness \_\_\_\_\_ Other  
Explain: \_\_\_\_\_

6. In the last five years, have you been admitted to a hospital or have you undergone any surgical procedures?  
Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what was the condition/treatment? \_\_\_\_\_

7. Please list all medications you are currently taking:  
a. \_\_\_\_\_ b. \_\_\_\_\_ c. \_\_\_\_\_

8. List the types of physical activities in which you participate: \_\_\_\_\_  
\_\_\_\_\_

9. At the present time, what are the most difficult tasks for you to perform? \_\_\_\_\_  
\_\_\_\_\_

10. Females: Are you now or is there a chance that you are pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

THERAPIST SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_