



MEDICAL HISTORY FORM

Please complete the following. If you do not understand a question, please ask your therapist to assist you.

NAME _____ TODAY'S DATE _____
 Date of Birth _____ Height _____ Weight _____ Gender: M F

Do you have a pacemaker? Yes No **Are you pregnant? Yes No**
 Occupation: _____ Presently working: Full Time _____ Part Time _____ Not Employed _____

Physical Activities at Work: _____
 General Health: Excellent __ Good __ Average __ Fair __ Poor __
 Date of Last Physical Exam: _____ Exercise Level: None __ 1-2x's/wk __ 3-4x's/wk __ 5+x's/wk __
 Type of Exercise: _____
 Do you experience any symptoms during heavy exercise? Y N
 If **yes** please explain: _____
 Stress Level: Low __ Medium __ High __
 Hobbies: _____

Are you currently seeing any of the following?
Medical Doctor Yes No **Psychiatrist/Psychologist** Yes No **Chiropractor** Yes No **Dentist** Yes No **Physical Therapist** Yes No

If you have seen any of the above in the last 3 months, please describe for what reason (illness, medical condition, physical exam, etc.): _____

In the past 6 months, have you had?

Difficulty with bowel/bladder control	Y	N	Fever/Chills	Y	N	Numbness	Y	N	Numbness in the genital/anal area	Y	N
Night/Pain Sweats	Y	N	Weakness	Y	N	Chest Pains	Y	N	Vision/Hearing Problems	Y	N
Unexplained weight gain	Y	N	Leg Swelling	Y	N	Dizziness	Y	N	Bodily Discomfort	Y	N
Shortness of Breath	Y	N	Fainting	Y	N	Leg Swelling	Y	N	Other:		

Have you ever been diagnosed as having any of the following?

Emphysema/Bronchitis	Y	N	Asthma	Y	N	Kidney Disease	Y	N	Heart Problems	Y	N
Thyroid Problems	Y	N	Diabetes	Y	N	Hepatitis	Y	N	Rheumatoid Arthritis	Y	N
Tuberculosis	Y	N	Depression	Y	N	Epilepsy/Seizures	Y	N	Chemical Dependency/Alcoholism	Y	N
Anemia	Y	N	Stroke	Y	N	Heart Problem	Y	N	High Blood Pressure	Y	N
Multiple Sclerosis	Y	N	Allergies	Y	N	Cancer	Y	N	Other Arthritic condition	Y	N

If you marked yes for Cancer what kind? _____

Do you have any of the following risk factors for Heart Disease?

High Blood Pressure **Yes No** Diabetes **Yes No** High Cholesterol **Yes No** Smoking **Yes No**
 Heart Disease **Yes No** Family History of Heart Disease **Yes No**

Amount of Alcohol Consumption (# of Drinks) per Week _____ Number of Cigarettes/Cigars per Week _____

Does any injury or condition significantly impact your function in these areas?

Work YES NO Food/Meals YES NO Safety YES NO Personal Care YES NO Mobility at Home YES NO
 Transportation YES NO Finances YES NO Emotional Stability, including withdrawal or depression YES NO

Do you have adequate support at home – physical and emotional – to meet the challenges of your condition? **YES NO**



Please list any surgeries or conditions for which you have been hospitalized which may pertain to your condition.

<u>Date</u>	<u>Surgery/Hospitalization</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications including prescriptions, herbal remedies and over the counter, in any form (pills, injections, skin patches) are you currently taking?

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Form reviewed with patient? Yes No

Therapist Signature Date