**Medical History Form**

*Please answer the following questions as accurately as possible.*

Are you? [ ] Right handed [ ] Left Handed

**Social History:**

Language [ ] English [ ] Interpreter needed? Language\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

With whom do you live? [ ] Spouse [ ] Alone [ ] Children [ ] Spouse & others [ ] Other

Employment/Work (job/school):

[ ] Full time [ ] Part time [ ] Retired [ ] Student [ ] unemployed [ ] Disabled

**Living Environment:**

Do you use? [ ] Crutches [ ] Cane [ ] Walker [ ] standard wheelchair [ ] Power wheelchair

Oxygen? [ ] supplemental [ ] continuous Liters per min: \_\_\_\_\_\_

Does your home have? [ ] Stairs, no railing [ ] Stairs, with railing [ ] Ramp [ ] Elevator

[ ] Elevated toilet seat [ ] Grab bars [ ] Tub bench [ ] Shower chair [ ] Other: \_\_\_\_\_\_

**Social habits:** [ ] Regular exercise [ ] Smoking [ ] Sports: \_\_\_\_\_\_\_\_\_\_\_\_

[ ] Recreational hobbies: \_\_\_\_\_\_\_\_\_\_\_\_

General health status: [ ] Excellent [ ] Good [ ] Fair [ ] Poor

**Medical/Surgical History:** (check all that apply)

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Arthritis |  | Blood Disorder |  | Diabetes |  | Seizures / Epilepsy |  | Kidney Disease |
|  | Head Injury |  | Heart Problems |  | Glaucoma |  | Circulation Problems |  | Stomach Problems |
|  | Fractures |  | Prostate Disease |  | Cancer |  | High Blood Pressure |  | Skin Disease |
|  | Osteoporosis |  | Thyroid Problems |  | Stroke |  | Low Blood Pressure |  |  |
|  | Osteopenia |  | Back/Neck Surgery |  | Lung Problems |  | Neuromuscular Disease |  |  |

Have you had any recent surgery or hospitalization? [ ] Yes [ ] No

When?\_\_\_\_\_\_\_\_\_ Surgery type: \_\_\_\_\_\_\_\_\_\_\_\_ Surgical Precautions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current condition / Chief complaint:**

Problem for which you are seeking physical therapy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

When did the problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had this problem before? [ ] Yes [ ] No If so, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pain:** Please rate your pain on a scale of **0** (no pain) to **10** (worst possible pain)

***Average*** pain: \_\_\_\_\_ At its ***Best***: \_\_\_\_\_ At its ***Worst***: \_\_\_\_\_

What makes your pain better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes your pain worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your pain: [ ] Dull [ ] Sharp [ ] Constant [ ] Intermittent [ ] Shooting [ ] Burning

[ ] Radiating [ ] No pain [ ] Other \_\_\_\_\_\_\_\_\_\_

**Clinical tests:** (check all that apply)

[ ] X-ray [ ] MRI [ ] CT scan [ ] Bone Density [ ] Other \_\_\_\_\_\_\_\_\_\_

Where were these done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When were these done? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Receiving home care services? [ ] Yes [ ] No Date of last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Functional status / Activity level:** (check all that apply)

⃝ Difficulty with bed mobility (rolling, sitting) ⃝ Difficulty with transfers (bed to chair)

⃝ Difficulty with self- care (dressing, bathing) ⃝ Difficulty with work activities

⃝ Difficulty with home management (cooking) ⃝ Difficulty with recreational activities

⃝ Difficulty with walking [ ] level ground [ ] uneven surfaces [ ] stairs [ ] ramps

**Current medications:** Please include all medications

Medication Dosage Times per day Reason for taking

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

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

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