

SANDY PHYSICAL THERAPY

Patient Medical History

To insure you receive a complete and thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, your therapist will assist you. Thank you!

Name: _____ **Date:** _____

Describe what happened: _____

List your occupation: _____ Date of Injury: _____

Please check if you are currently seeing any of the following healthcare professionals:

Medical Doctor _____ Psychiatrist/Psychologist _____ Osteopath _____

Occupational Therapist _____ Dentist _____ Chiropractor _____ Other _____

If you have seen any of the above during the past **three months**, please describe for what reason (illness, medical condition, physical, surgery/hospitalization, etc.):

Date	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Have you **ever** been diagnosed as having any of the following conditions? Please answer yes or no.

<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>	
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV positive
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Chemical dependency
<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema/Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding disorders
<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Cancer (if yes, what kind) _____			

Are you currently pregnant? Yes No Due Date (if yes): _____

Have you recently experienced unexplained weight loss or gain? Yes No

Have you experienced loss of bowel or bladder control? Yes No

Are you experiencing any of the following? Please answer yes or no.

YES NO

- Dizziness
- Drop Attacks
- Changes in Moles

YES NO

- Difficulty Speaking
- Double Vision

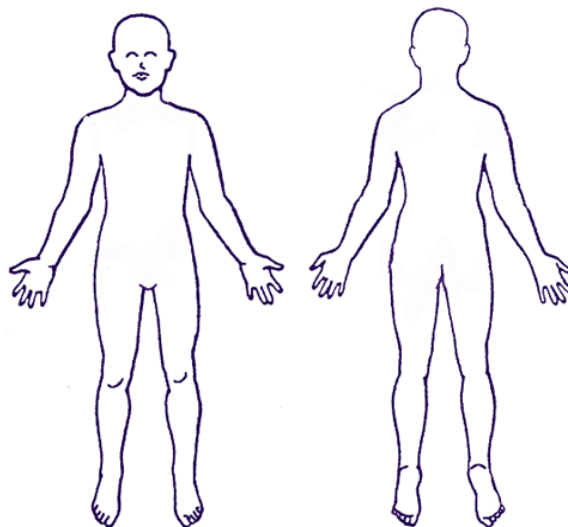
YES NO

- Difficulty Swallowing
- Numbness

List any other information that would assist us with your care: _____

Which **Over-The-Counter** medications have you taken in the last week?

- _____ Aspirin
- _____ Tylenol
- _____ Advil/Motrin/Ibuprofen
- _____ Laxatives
- _____ Decongestants
- _____ Antihistamines
- _____ Antacids
- _____ Vitamins/mineral supplements
- _____ Other



Please list any **Prescription** medication you are currently taking, including pills, injections, and/or skin patches:

Please indicate areas of pain and discomfort (on the figures above) using the following symbols:

- /// = Pain
- *** = Numbness, no feeling at all
- +++ = Tingling, asleep, abnormal feeling