## Patient Medical History

		Today's Date//_
Name	Date of birth	Gender M F
Occupation Is your condition preventing you from do	ning your job? Ves Mostly	Somewhat A little Not at all
Why are you seeking Physical Therapy?	oning your job? i es Mostry _	SomewhatA fittle Not at all
why are you seeking rhysical rherapy:		
What do you hope to achieve from Physi	cal Therapy?	
Are you having difficulty/pain with any of	of the following activities? (Mark a	all that apply).
Sleeping	Sitting	Carrying objects
Rolling in bed	Rising from sitting	Self-Care
Getting out of bed	Sitting down	Self-grooming
Lying down	Driving	Getting dressed
Walking	Bending over	Working
Standing	Squatting down	Sports
Going down stairs	Rising from squatting	Sex
Going up stairs	Lifting objects	Hobbies
List any surgeries in the past year.		
List any major surgery		
List any residual effects that you have fro	om previous surgery.	
List any trauma that you have experience	ed? (car accident, fall, etc.)	
	ed? (car accident, fall, etc.)	
List any trauma that you have experience	ed? (car accident, fall, etc.)	
List any residual effects from the trauma	ed? (car accident, fall, etc.)	
List any residual effects from the trauma.  Have you had any special tests regarding	ed? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT	scan, MRI, etc.)
List any residual effects from the trauma	ed? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT	scan, MRI, etc.)
List any residual effects from the trauma.  Have you had any special tests regarding Results of test?	ed? (car accident, fall, etc.)	Scan, MRI, etc.)
List any residual effects from the trauma.  Have you had any special tests regarding	ed? (car accident, fall, etc.)	Scan, MRI, etc.)
List any residual effects from the trauma.  Have you had any special tests regarding Results of test?  Please list your current medications if your	ed? (car accident, fall, etc.)	Scan, MRI, etc.)
Have you had any special tests regarding Results of test?	ed? (car accident, fall, etc.)	Scan, MRI, etc.)
List any residual effects from the trauma.  Have you had any special tests regarding desults of test?  Please list your current medications if your lealth History (mark all that apply)	ed? (car accident, fall, etc.) your condition? Y N (X-ray, CAT u have not provided a list. (List pro	Sean, MRI, etc.)
List any residual effects from the trauma.  Lave you had any special tests regarding tesults of test?  Lease list your current medications if your leasth History (mark all that apply)  High blood pressure	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro	Scan, MRI, etc.)  Divided)  Polycystic Fibrosis
Lave you had any special tests regarding desults of test?  Lease list your current medications if your leasth History (mark all that apply)  High blood pressure  Heart disease/chest pain	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue  Currently Pregnant	Polycystic Fibrosis Arthritis (OA, RA, etc.)
List any residual effects from the trauma.  Have you had any special tests regarding essults of test?  Please list your current medications if your lealth History (mark all that apply)  High blood pressure  Heart disease/chest pain  Heart Attack	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer
ist any residual effects from the trauma.  Iave you had any special tests regarding desults of test?  Iease list your current medications if your lealth History (mark all that apply)  High blood pressure  Heart disease/chest pain  Heart Attack  Pace Maker	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease
Alaye you had any special tests regarding tesults of test?  Please list your current medications if your leasth History (mark all that apply)  High blood pressure  Heart disease/chest pain  Heart Attack  Pace Maker  Stroke	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease
List any residual effects from the trauma.  Lave you had any special tests regarding desults of test?  Lease list your current medications if your least History (mark all that apply)  High blood pressure  Heart disease/chest pain  Heart Attack  Pace Maker  Stroke  Headache	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS)
Less list your current medications if you leasth History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD,	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease
ist any residual effects from the trauma.  Iave you had any special tests regarding tesults of test?  Iease list your current medications if your lealth History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.)	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders
Lave you had any special tests regarding desults of test?  Lease list your current medications if your least History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity Anxiety	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness
Alaye you had any special tests regarding tesults of test?  Please list your current medications if your least History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough Liver disease/disorders	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity  Anxiety Depression	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness Falls
ist any residual effects from the trauma.  Iave you had any special tests regarding results of test?  Iease list your current medications if your lealth History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough Liver disease/disorders Kidney disease/disorders	cd? (car accident, fall, etc.)  your condition? Y N (X-ray, CAT)  u have not provided a list. (List pro  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity  Anxiety Depression Psychological Disorders	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness Falls Chronic Pain
Alaye you had any special tests regarding desults of test?  Please list your current medications if your desults of test?  Health History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough Liver disease/disorders Kidney disease/disorders Multiple Sclerosis	cd? (car accident, fall, etc.)  ryour condition? Y N (X-ray, CAT)  u have not provided a list. (List provided a list. (List provided a list.)  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity  Anxiety Depression Psychological Disorders Osteoarthritis/Osteopenia	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness Falls Chronic Pain Stomach Issues
Alaye you had any special tests regarding Results of test?  Please list your current medications if your Health History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough Liver disease/disorders Kidney disease/disorders Multiple Sclerosis Parkinson's Disease	cd? (car accident, fall, etc.)  Tyour condition? Y N (X-ray, CAT)  The unique of provided a list. (List provided a list. (List provided a list.)  Chronic Fatigue  Currently Pregnant  Menopause  Chronic Infection  Seizures  Diabetes  Obesity  Anxiety  Depression  Psychological Disorders  Osteoarthritis/Osteopenia  Insomnia/Narcolepsy	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness Falls Chronic Pain Stomach Issues Blood Disorders
Alaye you had any special tests regarding Results of test?  Please list your current medications if your Health History (mark all that apply)  High blood pressure Heart disease/chest pain Heart Attack Pace Maker Stroke Headache Respiratory Problems (COPD, asthma, etc.) Persistent Cough Liver disease/disorders Kidney disease/disorders Multiple Sclerosis	cd? (car accident, fall, etc.)  ryour condition? Y N (X-ray, CAT)  u have not provided a list. (List provided a list. (List provided a list.)  Chronic Fatigue Currently Pregnant Menopause Chronic Infection Seizures Diabetes Obesity  Anxiety Depression Psychological Disorders Osteoarthritis/Osteopenia	Polycystic Fibrosis Arthritis (OA, RA, etc.) Cancer Degenerative Disc Disease Degenerative Joint Disease GI Disorders (acid reflux, IBS) Thyroid Disorders Dizziness Falls Chronic Pain Stomach Issues