PREMIER
PHYSICAL THERAPY
AND SPORTS MEDICINE

MEDICAL HISTORY FORM

Patient Name	Date of Birth	Today's Date	Date of Next Physician Visit

Reason for Coming to Therapy: _____

How did you hear about us? _____

When did the problem begin? _____

How did the problem begin? _____

Have you had the problem before? _____ If YES, How long did the problem last? _____

Are your symptoms due to:

☐ Sports ☐ Work Injury* ☐ Trauma ☐ Unknown ☐ Chronic ☐ Overuse

☐ Motor Vehicle Accident*

* If yes to Work Injury or MVA Date of Injury _____ Country _____ State _____

Since onset, Are your symptoms: (Circle) SAME BETTER WORSE

Since onset, have you had:

☐ MRI ☐ X-Ray ☐ CT Scan ☐ Ultrasound ☐ Nerve Conduction

☐ Bone Scan ☐ Blood Tests ☐ Injections

☐ Other _____

Results from above tests: _____

Do you currently smoke or use tobacco? ☐ Yes ☐ No How many packs / day? _____

Are you or could you be pregnant? ☐ Yes ☐ No

Which treatment have you, or are you currently receiving for THIS condition?

☐ Massage Therapy ☐ Injections ☐ Bed Rest ☐ Medications ☐ Physical Therapy

☐ Chiropractor ☐ Nerve Blocks

☐ Other _____ **When?** _____

What activities does your job require / how many hours at each?

☐ Sitting _____ ☐ Computer _____ ☐ Standing _____ ☐ Walking _____

☐ Lifting How many lbs? _____ ☐ From Floor ☐ Overhead

☐ Other _____

Which of those activities are you having trouble with? _____

What was your previous functional level?

Limited with functional activities: ☐ Yes ☐ No

Limited with work activities: ☐ Yes ☐ No

Limited with recreational activities: ☐ Yes ☐ No

Other: _____

MEDICAL HISTORY FORM (page 2)

Patient Name _____ Date of Birth _____

Any Previous Surgeries: _____

Are you allergic to Latex? ☐ Yes ☐ No If YES, Describe your reaction: _____

Are your symptoms worse in the: ☐ AM ☐ PM ☐ Same

Please check the activities that increase your symptoms:

- ☐ Walking: with device
- ☐ Walking: uneven terrain
- ☐ Walking: indoors
- ☐ Walking: outdoors
- ☐ Balance/ Safety
- ☐ Sports
- ☐ Bathing/ Showering
- ☐ Bed Mobility
- ☐ Bending
- ☐ Care Giving: infants/others
- ☐ Dressing
- ☐ Carrying: Groceries
- ☐ Carrying: other objects
- ☐ Carrying: laundry
- ☐ Cleaning
- ☐ Cooking
- ☐ Crawling
- ☐ Lying on stomach/ back
- ☐ Lying on Right /left
- ☐ On/ Off: Shoes/ Socks
- ☐ Belt/ Bra
- ☐ Driving
- ☐ Eating/ Utensils
- ☐ Gripping _____
- ☐ Grocery Shopping
- ☐ House Hold Chores
- ☐ Jumping
- ☐ Kicking
- ☐ Kneeling
- ☐ Ladders
- ☐ Lifting: from floor
- ☐ Lifting: overhead
- ☐ Load/Unload Dishwasher
- ☐ Curbs/Ramps
- ☐ Buttons
- ☐ Opening Jars
- ☐ Open/Close Doors
- ☐ Pulling _____
- ☐ Reaching: under cabinet
- ☐ Reaching: overhead
- ☐ Running
- ☐ Sewing
- ☐ Sitting _____
- ☐ Squatting
- ☐ Stairs: up/ down
- ☐ Standing _____
- ☐ Transfers: sit ⇔ stand
- ☐ Transfers: sit ⇔ lying
- ☐ Typing
- ☐ Writing
- ☐ Yard Work
- ☐ Pushing
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Please Check the following activities that RELIEVE your symptoms:

☐ Rest ☐ Heat ☐ Ice ☐ Sitting ☐ Walking ☐ Standing
☐ Lying Down ☐ Modify Activity ☐ Stop Activity ☐ Medication
☐ Other _____

Please describe your pain?

☐ Dull ☐ Sharp ☐ Achy ☐ Burning ☐ Steady ☐ Numbness
☐ Radiating ☐ Pins/Needles
☐ Other _____

Have you ever experienced any of the following, since the onset of your symptoms?

☐ Recent Fever / Chills ☐ Nausea / Vomiting ☐ Urgency/Straining with Urination
☐ Dizziness / Vertigo ☐ Unexplained Weight Loss ☐ Incontinence

MEDICAL HISTORY FORM (page 3)

Patient Name _____ Date of Birth _____

Please check all of the following conditions regarding your medical history:

- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Aneurysm
- ☐ Alcohol Use
- ☐ Bleeding
- ☐ Blood Clots
- ☐ Blood Pressure (↑ / ↓)
- ☐ Cancer
- ☐ Chicken Pox/Shingles
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes
- ☐ Difficulty Speaking
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Frequent Falls
- ☐ Glaucoma
- ☐ Gout
- ☐ Head Injury
- ☐ Headaches
- ☐ Hearing problems
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ HIV / AIDS
- ☐ Incontinence
- ☐ Insomnia
- ☐ Kidney Stones
- ☐ Kidney/Bladder problems
- ☐ Lactating
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Lupus
- ☐ Memory problems
- ☐ Mental health issues
- ☐ Metal Implants
- ☐ Multiple Sclerosis
- ☐ Night Sweats
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Peripheral vascular issues
- ☐ Pregnant
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sent
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Stroke
- ☐ Swallowing problems
- ☐ Swelling of arms or legs
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Vision problems
- ☐ Other: _____

What is the Frequency of your Pain?

☐ Constant ☐ Daily ☐ Less than daily ☐ Less than weekly

☐ Other _____

What activities do you wish to return to? _____

Have you ever received treatment for any of the following?

☐ Abdomen ☐ Back ☐ Knee ☐ Elbow ☐ Foot/Ankle ☐ Pelvis

☐ Hand ☐ Head ☐ Hip

☐ Other: _____

If Yes, Please describe: _____

When being taught about HealthCare, what methods do you prefer? (Please check all that apply)

☐ Written Materials ☐ Demonstration ☐ Verbal Instructions

☐ Other: _____

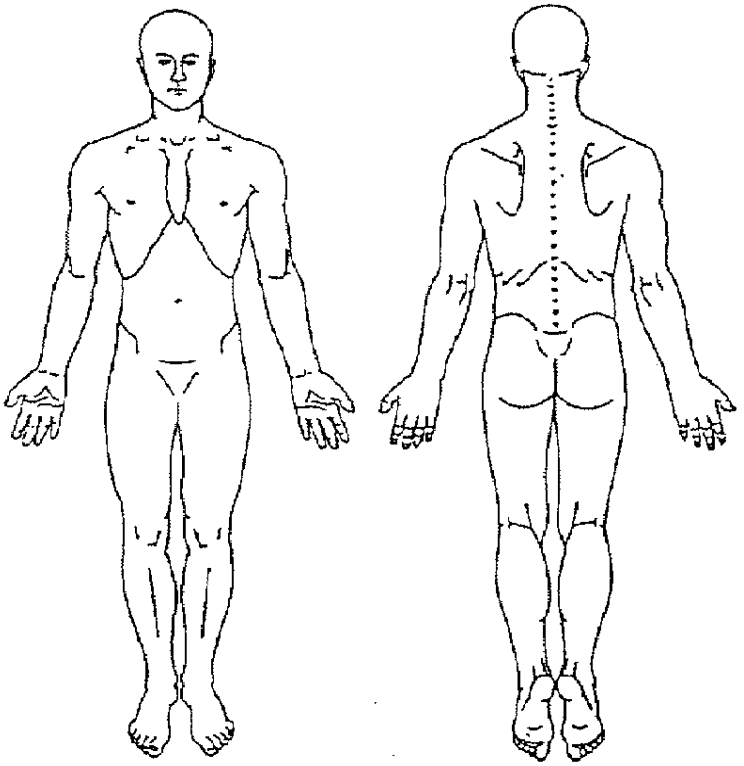
MEDICAL HISTORY FORM (page 4)

Patient Name _____ Date of Birth _____

Please Rate Your Pain Scale: Current: _____ Best: _____ Worst: _____

0 No Pain
1 Mild, you are aware, but it doesn't bother you
2 Mild; more aware, begins to bother you
3 Moderate; tolerate without medication
4 Moderate; tolerate with medication
5 Severe; affects life
6 Severe; cannot participate in activities
7 Very Severe; cannot participate in daily activities
8 Intensely Severe; cannot leave the house
9 Extremely Severe; cannot get out of bed
10 Most Severe; contemplate going to the ER

Please indicate with an "X" where your pain is.



Do you or your caregivers have any special learning or spiritual needs that we need to consider? ☐ Yes ☐ No
If Yes, Please describe: _____

Is there any other important information that we need to know to provide care? _____

Do you ever feel unsafe in your home? ☐ Yes ☐ No
If Yes, Please describe: _____

Do you ever have thoughts of self harm? ☐ Yes ☐ No

Patient Signature: _____ **Date:** _____

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Patient Signature: ☺ _____

Date: ☺ _____