

Patient Medical History

Name: _____ Referring Physician: _____

Family Physician: _____ First Doctor Visit for this injury: _____

Last date worked due to this injury: _____ Date returned to work after this injury: _____

Is there an attorney involved with this case? _____ Date of next doctor visit: _____

Have you had surgery for this injury? _____ Number of Surgeries: _____ Date(s) _____

Type of Surgery: _____

Where did your surgery take place: _____

Current Level of Pain (0 being no pain, 10 being pain requiring Emergency Room care)

(Circle only one) 1 2 3 4 5 6 7 8 9 10

ARE YOU CURRENTLY TAKING ANY PRESCRIPTION OR OVER THE COUNTER MEDICATIONS: _____

If yes, please list: _____

PLEASE CHECK ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES YOU HAVE RECEIVED FOR THIS CONDITION

____ Orthopedist	____ Physical Therapy	____ X-rays	____ EMG
____ Occupational Therapy	____ CT Scan	____ NCV	____ Neurologist
____ Massage Therapy	____ MRI	____ Injection	____ General Practitioner
____ Myelogram	____ Cast or Brace	____ Emergency Room Care	
____ Chiropractor	____ Other: _____		

PLEASE CIRCLE ANY OF THE FOLLOWING ITEMS THAT PERTAIN TO YOUR HEALTH HISTORY

Asthma	Sleeping Problems	Allergies	Shortness of Breath
Emotional	Psychological	Anemia	Coronary Heart Disease
Headaches	Infectious Disease	Chest Pain	Numbness or Tingling
Neurological Problems	Do you have a Pacemaker?	Dizziness or Fainting	Diabetes
High Blood Pressure	Blurred Vision	Metal Implants	Heart Attack
Ringing in the ears	Cancer	Heart Surgery	Weakness
Do you Smoke?	Stroke or TIA	Weight loss	Arthritis or Swollen Joints
Blood Clot or Emboli	Night Sweats	Are you Pregnant?	Epilepsy or Seizures
Hernia	Osteoporosis	Thyroid Trouble	Varicose Veins

Other: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD IN THE PAST: _____

PLEASE LIST THREE GOALS YOU WOULD LIKE TO ACHIEVE WHILE IN THERAPY:

1. _____
2. _____
3. _____

EMERGENCY CONTACT: _____ PHONE: _____

PATIENT OR GUARDIAN SIGNATURE: _____ Date: _____