Forward Motion Physical Therapy

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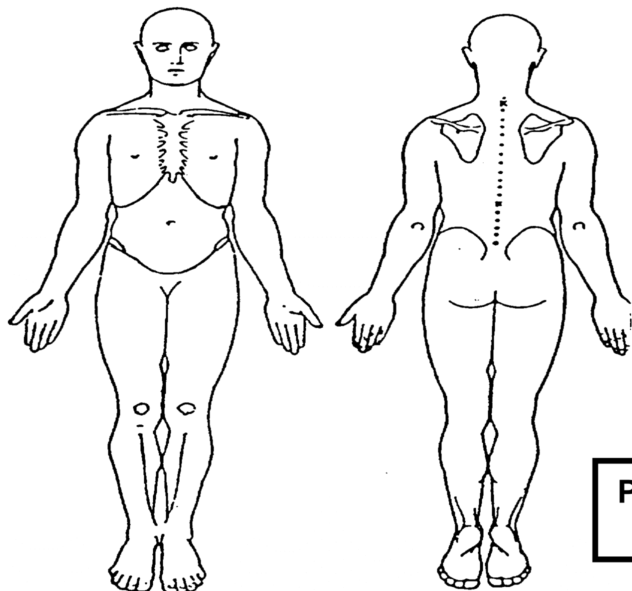
MEDICAL HISTORY

Patient Name: ______________________ DOB: __________ Date: __________
Email: ______________________ Phone: ______________________
Address: ______________________ Insurance: ______________________
Emergency Contact: (Name) ______________________ (Phone) ______________________
Referring MD if a/p ______________________ Primary MD: ______________________
What problems are you currently having? ______________________
How did this happen? ______________________
____
Date of injury: ______________________ Date of Surgery: ______________________
Current level of pain (circle)? 0 1 2 3 4 5 6 7 8 9 10
(0 = no pain) (10 = worst imaginable pain)



Please indicate on the body chart where you have:
Pain Numbness or Tingling Other symptoms

Do you understand your diagnosis / reason for being here? Yes No
Are you aware of your prognosis / expected outcome? Yes No
What are your expectations / goals for Physical Therapy? ______________________
____
Have you had physical or occupational therapy for this? Yes No Dates of PT/OT: ______________________
Have you had physical or occupational therapy for any other condition? Yes No
If yes, Please describe nature of prior problem: ______________________

Review of medical services for this injury / episode: Please Check

- ☐ Emergency Room Care Date: ______________
- ☐ X-Ray
- ☐ MRI
- ☐ Cortisone Injection Dates: ______________
- ☐ Trigger Point Injection
- ☐ Acupuncture
- ☐ Orthopedist
- ☐ Neurosurgeon
- ☐ Chiropractor
- ☐ Neurologist
- ☐ Rheumatologist
- ☐ Massage Therapy

Medications for this condition: ______________________

Since the onset of current symptoms have you had?

- ☐ Any difficulty with control of bowel or bladder function
- ☐ Any numbness in the genital or anal area
- ☐ Any dizziness or fainting attacks
- ☐ Unexplained weight changes
- ☐ Malaise (vague feeling of bodily discomfort)
- ☐ Fever / Chills
- ☐ Numbness
- ☐ Weakness
- ☐ Night Pains / Night Sweats
- ☐ Problems with vision/hearing

Please turn over and complete

Review of Medical History: Please Check any conditions that you may have had.

☐ Cancer, Date:____________
☐ Chemotherapy / Radiation
☐ Angina / Chest Pain
☐ High Blood Pressure
☐ Heart Attack, Date:___________
☐ Heart Surgery, Date:__________
☐ Pacemaker, Date:____________
☐ Stroke / TIA, Date:___________
☐ Blood Clot, Date:____________
☐ Lyme Disease

☐ Asthma / Shortness of Breath
☐ Emphysema / COPD
☐ Diabetes / Neuropathy
☐ Numbness / Tingling
☐ Osteoarthritis / Rheumatoid
☐ Joint Replacements
☐ Osteoporosis
☐ Loss of Balance/Falling
☐ Dizziness / Fainting
☐ Epilepsy / Seizures

☐ Current / Past Pregnancy
☐ Hepititis / Liver / Blood Disorder
☐ Kidney Disease
☐ Bowel or Bladder Dysfunction
☐ Gastrointestinal Problems
☐ Headaches / Migranes
☐ Vision or Hearing Problems
☐ Chronic Fatigue / Sleeping Difficulties
☐ Memory Loss / Attention Difficulties
☐ Depression or Anxiety Problems

Please list all surgeries, hospitalizations, or complications:____

____

List all other Medications: ____

Do you smoke? Yes No Packs per day: ________________

Do you drink alcoholic beverages? Yes No Drinks per week: ______________

How much caffeinated coffee or caffeine containing beverages do you drink per day: ___________________

Occupational Status Which describes your working status?

_____ Disabled/On Disability From when? _______ For what condition: ____________________________________

____ Employed # Hrs/week ___________ Occupation: ____

____ Without Restrictions ____ With Restrictions given by (circle): MD Employer Self

Off work due to injury Since:

Does your condition or pain level restrict your full activity? Yes No

If yes, please Check:

☐ Sitting
☐ Standing
☐ Walking
☐ Stairs
☐ Squatting
☐ Bending
☐ Lifting
☐ In & Out of Chair

☐ Grasping / Reaching
☐ Writing / Reading
☐ Dressing / Grooming
☐ Preparing Meals
☐ Housework / Yardwork
☐ Driving / Transportation
☐ Sleeping
☐ In & Out of Bed

☐ Concentration
☐ Sports: Basketball / Baseball
Football / Hockey
Soccer / Softball
Wrestling / Running
Golf / Tennis
☐ Other:___________________
____

Please comment on specific problems or difficulties:____

Personal/Social

Live with: Self/Alone Spouse Family Other:________________________

Are you a caregiver for someone else? Yes No

Previous Recreational/Sports Activities (please circle prior to current injury)

Hobbies: ____

Exercise Level: ☐ Zero ☐ 1-2x/wk ☐ 3-4 days/wk ☐ 5+ days/wk

Sports: Cycling Swimming Running Triathlons Duathlons golf hockey downhill skiing tennis running walking

Other: ____

Please describe how regular you participate in your sports: _____________________________________

How long have you participated in your sport:____

If a runner, Please list:

times/week you run:__________ Average distance:__________ Average time:__________

If you go to a gym, Please list:

times/week:________________

Please circle:

Free weights Weight Machines(Cybex/Nautlis) Treadmill Stationary Bike Elipse

I attest that the information provided above is current and correct to my knowledge.

Patient / Guardian Signature: