

PERFORMANCE PT

physical therapy + sports training

Patient Medical History Form

NAME: _____ Referring Physician: _____

Family Physician: _____ Occupation: _____

Have you had surgery for this injury? _____ Last date worked due to this injury: _____

Surgical procedure and date: _____

Are you currently taking any prescription or non-prescription medications? YES NO

Anti-inflammatories _____

List other medications _____

Pain medications _____

Muscle relaxors _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Physical therapy	_____	_____	General practitioner	_____	_____
Occupational therapy	_____	_____	Orthopedist	_____	_____
Emergency room care	_____	_____	Neurologist	_____	_____
EMG/NCV	_____	_____	X-rays	_____	_____
Myelogram	_____	_____	MRI	_____	_____
Chiropractor	_____	_____	CT Scan	_____	_____
Massage therapy	_____	_____	Podiatrist	_____	_____

What was your physical level of function prior to the onset of the condition for which we are seeing you? _____

Do you now have, or have you ever had, any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	_____	_____	Severe or Frequent Headaches	_____	_____
Shortness of Breath/Chest pain	_____	_____	Vision or Hearing Difficulty	_____	_____
Coronary Heart Disease or Angina	_____	_____	Numbness or Tingling	_____	_____
Pacemaker	_____	_____	Dizziness or Fainting	_____	_____
High Blood Pressure	_____	_____	Weakness	_____	_____
Heart Attack/Heart Surgery	_____	_____	Weight Loss/Energy Loss	_____	_____
Blood Clot/Emboli	_____	_____	Hernia	_____	_____
Stroke/TIA	_____	_____	Epilepsy/Seizures	_____	_____
Allergies	_____	_____	Thyroid trouble/Goiter	_____	_____
Any Pins or Metal Implants	_____	_____	Anemia	_____	_____
Joint replacement	_____	_____	Bowel or Bladder Problems	_____	_____
Diabetes	_____	_____	Neck Injury / Surgery	_____	_____
Infectious Diseases	_____	_____	Shoulder Injury / Surgery	_____	_____
Cancer/Chemotherapy/Radiation	_____	_____	Elbow / Hand Injury or Surgery	_____	_____
Arthritis / Swollen Joints	_____	_____	Back Injury or Surgery	_____	_____
Osteoporosis	_____	_____	Knee Injury or Surgery	_____	_____
Sleeping problems or difficulties	_____	_____	Leg/Ankle/Foot Injury / Surgery	_____	_____
Emotional / Psychological Problems	_____	_____	Do you smoke?	_____	_____
Are you pregnant?	_____	_____	Satisfied with your weight?	_____	_____

Please rate your pain (0 no pain – 10 extreme pain) _____ Currently _____ At Rest _____ With Activity

What are your expectations/goals while in this program? _____

Do you have difficulty with any of the following as a result of your current medical condition?

	YES	NO		YES	NO
Transportation	_____	_____	Financial stress	_____	_____
Safety issues at home	_____	_____	Coping with current condition	_____	_____

Patient / Guardian Signature: _____ Date: _____

PT Initials: _____