PATIENT MEDICAL HISTORY

Name: ______________________________ Referring Physician: ______________________________

Family Physician: ______________________________ Date of First Doctor Visit for this Injury: ______________

Last Date Worked Due to this Injury: _________________ Date Returned to Work After Injury: _________________

Is an Attorney Involved in this Case? YES NO

Have you had Surgery for this Injury? YES NO Number of Surgeries: 1 2 3 4 _____

Type of Surgery: ______________________________ Took Place in: Hospital Surgery Center

Are you Currently Taking Any Prescription or Non-Prescription Medications? YES NO

Anti-Inflammatories _____
Muscle Relaxers _____
Pain Medication _____

List Medications: ______________________________
____
____

Have you had any of the following Medical or Rehabilitative Services for the Injury/Episode?

	Yes	No		Yes	No		Yes	No
X-rays	___	___	Chiropractor	___	___	Physical Therapy	___	___
EMG/NCV	___	___	General Practitioner	___	___	Occupational Therapy	___	___
CT Scan	___	___	Neurologist	___	___	Massage Therapy	___	___
MRI	___	___	Orthopedist	___	___	Occupation Medicine Doctor	___	___
Myelogram	___	___	Podiatrist	___	___	Emergency Room Care	___	___

Other: ______________________________

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	___	___
Tuberculosis	___	___	Vision or Hearing Difficulties	___	___
Infectious Diseases	___	___	Dizziness or Fainting	___	___
Shortness of Breath/Chest Pain	___	___	Numbness or Tingling	___	___
Coronary Heart Disease or Angina	___	___	Neck Injury or Surgery	___	___
Heart Attack or Surgery	___	___	Back Injury or Surgery	___	___
Do you have a pacemaker?	___	___	Shoulder Injury or Surgery	___	___
High Blood Pressure	___	___	Elbow/Hand Injury or Surgery	___	___
Stroke/TIA	___	___	Knee Injury or Surgery	___	___
Blood Clot/Emboli	___	___	Leg/Ankle/Foot Injury or Surgery	___	___
Epilepsy/Seizures	___	___	Any Pins or Metal Implants	___	___
Sleeping Problems/Difficulties	___	___	Joint Replacement	___	___
Emotional/Psychological Problems	___	___	Arthritis/Swollen Joints	___	___
Anemia	___	___	Osteoporosis	___	___
Diabetes	___	___	Gout	___	___
Thyroid Trouble/Goiter	___	___	Varicose Veins	___	___
Cancer	___	___	Hernia	___	___
Allergies	___	___	Weakness	___	___
Bowel or Bladder Problems	___	___	Are you Pregnant?	___	___
Weight Loss/Energy Loss	___	___	Do you Smoke?	___	___

List any other information that would assist us in your care: ______________________________
____

Are you aware of what your diagnosis is? YES NO

Based upon your awareness, what are your expectations/goals while in this program? ______________________________
____

____

Patient/Parent/Guardian Signature **Date**

I have reviewed this medical history with the patient.

Therapist Signature: ______________________________ Date: ____________________