PAST MEDICAL HISTORY FORM

Name_____**Date**_____

Are you presently working? Y N Date of next physician's visit_____

Date of injury/onset_____ Have you experienced these symptoms before? Y N

Cause of injury: Auto Work Sports Unknown Other:_____

If work comp, currently working? Y N Restrictions? Y N Type of work_____

Do you have or have you had any of the following:

Diabetes	Y N	Hypoglycemia	Y N	Osteoarthritis	Y N
Chest Pain	Y N	Osteoporosis	Y N	High Blood Pressure	Y N
Hernia	Y N	Heart Disease	Y N	Rheumatoid Arthritis	Y N
Pacemaker	Y N	Seizures	Y N	Headaches/Migraines	Y N
Metal Implants	Y N	Kidney Problems	Y N	Dizziness/Fainting	Y N
Cancer	Y N	Fractures	Y N	Pelvic Floor Pain	Y N
Blood Disorder	Y N	Head Injury	Y N	Incontinence	Y N
Fibromyalgia	Y N	Jaw Pain/TMD	Y N	Liver/Gallbladder Problems	Y N
Depression	Y N	Bipolar	Y N	Anxiety disorder	Y N
Stroke	Y N	Ringing in Ears	Y N	Asthma/Breathing Difficulty	Y N

If you answered YES to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

_____

If female, are you pregnant? Y N Estimated Due Date:_____

Do you have any allergies? Y N If yes, please list_____

Are you presently taking any medication? Y N If yes, please list what medication and for what condition_____

_____

Do you participate in any sports, exercise program or activities on a regular basis: Y N

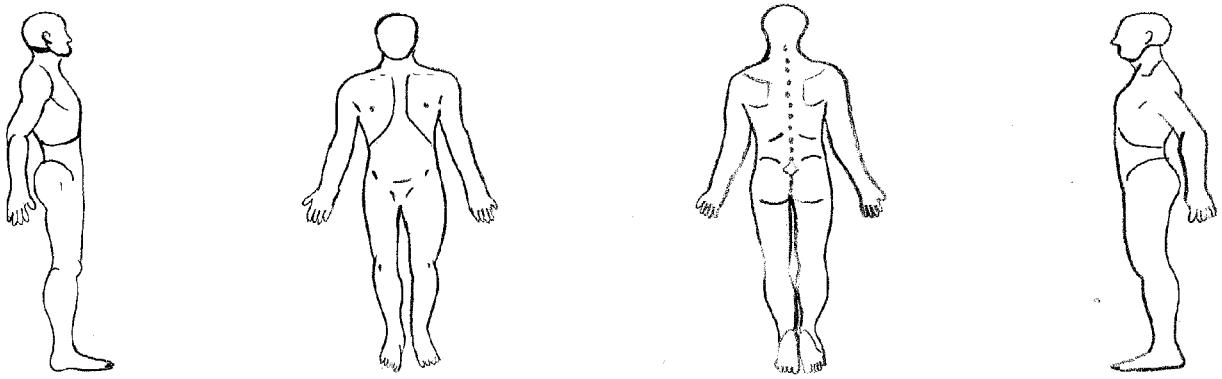
Please list: _____

Have you had any other treatment for this condition (currently or in the past)? Y N
If yes, please check:

____Surgery	____Physical Therapy	____CT Scan
____Medications	____Chiropractic	____MRI
____Injections	____X-rays	____EMG/NCV

____Other:_____
_____

Please indicate below where your symptoms are located: **KEY:** Numbness //////////
Tingling 0000000
Pain xxxxxxx



Place an "X" on the line below indicating your pain at its lowest and highest levels.

No Pain 0 l____l____l____l____l____l____l____l____l____l____l____l 10 Worst Pain

Current limitation (Please check all that apply)	____None
____Sitting	____Standing
____Sit to Stand	____Walking
____Lying Down	____Up/Down Stairs
____Bending	____Squatting
____Reaching	____Sleeping
____Taking a Deep Breath	____Talking/Chewing/Yawning
____Repetitive Activities	____Self Care/Hygiene
____Home management activities	____Sports/Recreation

What are your goals for physical therapy?_____

Patient/Guardian Signature:_____

Reviewed by therapist:_____Date:_____