PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? ☐ Yes ☐ No Date of next physician's visit: ___/___/___

Date of injury / onset: ___/___/___ Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

Check which apply to your symptoms:

☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: _____

Have you had a related surgery? ☐ Yes ☐ No Explain: _____

Do you have, or have you had any of the following in the last **FIVE** years?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest / Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heat Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Mental Health Issues	☐	☐	Stroke/CVA	☐	☐

If yes on any of the above, please briefly explain and give approximate date:

Past Surgical History and Date of Surgery:

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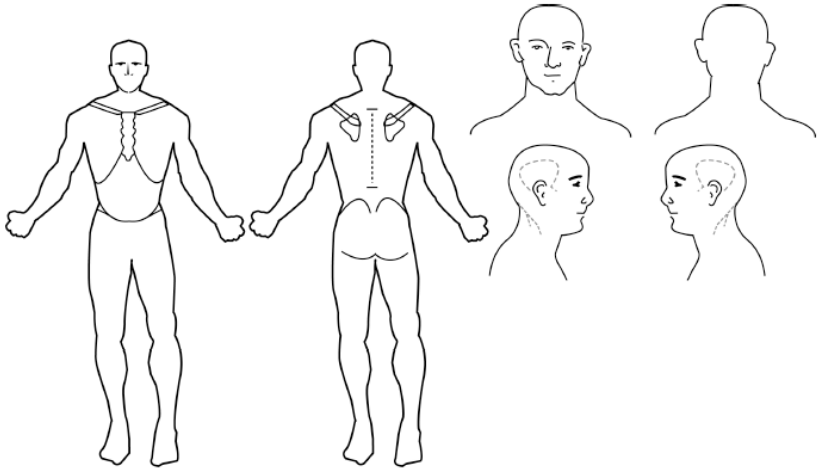
Are you presently taking Medication? ☐ Yes ☐ No

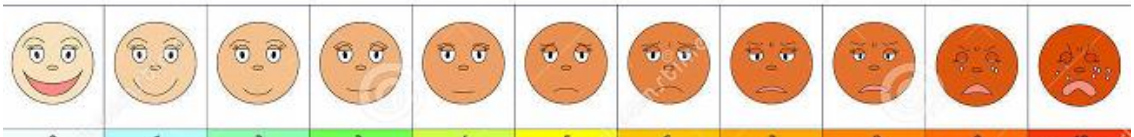
If yes, please list what medications and for what condition:

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe _____

Please indicate below where your symptoms are located.



COMPARATIVE PAIN SCALE CHART (Pain Assessment Tool)



0 Pain Free	1 Very Mild	2 Discomforting	3 Tolerable	4 Distressing	5 Very Distressing	6 Intense	7 Very Intense	8 Utterly Horrible	9 Excruciating Unbearable	10 Unimaginable Unspeakable
No Pain	**Minor Pain**			**Moderate Pain**			**Severe Pain**			
Feeling perfectly normal	Nagging, annoying, but doesn't interfere with most daily living activities. Patient able to adapt to pain psychologically and with medication or devices such as cushions.			Interferes significantly with daily living activities. Requires lifestyle changes but patient remains independent. Patient unable to adapt pain.			Disabling; unable to perform daily living activities. Unable to engage in normal activities. Patient is disabled and unable to function independently.			

Pain Rating at Present _____ Pain Rating at Worst _____ Pain Rating at Best _____

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