Performax Physical Therapy

PATIENT MEDICAL HISTORY

Date: __________ Name:________________________________ Birth Date:_________

• Problem Location

□ Neck □ Left □ Shoulder □ Elbow □ Wrist □ Hand
□ Back □ Right □ Hip □ Knee □ Ankle/Foot
□ Balance

• On what date did you first experience/notice this problem? _____________

• Please tell us where you were, what you were doing (if anything), what happened (if anything) and how bad your injury seemed to be at the time.__________________

• Have you had surgery? YES NO (*circle one*) Date_____________
(*If you had more than one surgery, enter the date of the last surgery.*)

• Describe the surgery. What condition did the surgeon correct? _________________

• On a scale of 0 (none) to 10 (extremely painful) what is your usual pain level? ___

• On the same scale, what is the least level of pain you experience? ____

• When is your pain the least? ________________________________

• On the same scale, what is the worst level of pain you experience? ____

• When is your pain the worst? ________________________________

• Prior to this problem, were you fully functional? YES NO (*circle one*)

• What is your occupation? ________________________________

• Have you had □ X-Rays □ MRI □ Bone Scan □ CAT Scan? What were the results? ________________________________

• Is a Home Health Agency assisting you in any way? YES NO (*circle one*)

• Are you currently seeing or have you seen in the past year, any of the following?

Physical Therapist YES NO For:______________________________

Doctor YES NO For:______________________________

Chiropractor YES NO For:______________________________

• Please check the box if you have recently experienced …

□ Weight Gain/Loss □ Nausea/Vomiting □ Fatigue
□ Weakness/Dizziness □ Fever/Chills/Sweats □ Numbness/Tingling

• Indicate which of the following over-the-counter medications you have taken in the last week.

□ Aspirin □ Laxatives □ Advil/Tylenol/Ibuprofen
□ Antihistamines □ Antacid □ Decongestants
□ Vitamins/Mineral Supplements □ Other ______________________

• Please list all the prescription medications you are currently taking _____________

• Do you smoke? YES NO (*circle one*) If 'YES', how much do you smoke?________

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- Do you have any bowel or bladder problems? YES NO (*circle one*)
- Any frequent coughing or sneezing? YES NO (*circle one*)
- Do you have frequent headaches? YES NO (*circle one*)
- Do you use □ Wheelchair □ Cane □ Walker □ Crutches □ Bracing □ Other
- Please indicate if you have ever been diagnosed with any of the following

□ Cancer	□ Heart Condition	□ Circulation Problems
□ Stroke	□ Respiratory Problems	□ High Blood Pressure
□ Hepatitis	□ Infectious Disease	□ Tuberculosis
□ Anemia	□ Thyroid Problems	□ Kidney Disease
□ Diabetes	□ Epilepsy	□ Rheumatoid Arthritis
□ Osteoporosis	□ Vertigo	□ Other Arthritic Conditions

- Do you have a pacemaker? YES NO (*circle one*)
- Do you have any implants? YES NO (*circle one*)
- Does your home have stairs that you must climb on a regular basis? YES NO
- Is there someone in your home to assist you during your rehab? YES NO
- Please tell us any other information that you think might be helpful in developing and implementing your treatment plan. Make sure to tell us of any precautions we must consider during your care. If you have any other conditions that could impact your treatment it is critical that you let your therapist know. ____________________

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Patient Signature: ______________________________ Date __________

Parent/Guardian: ______________________________ Date__________
(*if patient is under 18*)

Therapist Notes: ______________________________
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I have reviewed this document with the patient.

Therapist: ____________________ Signature:______________________