MEDICAL HISTORY

PATIENT NAME: _____Date: _____

Date of Injury / Onset: _____ Date of Surgery: _____

Right or Left Handed? ____ Which Side is Injured? R____ L____ Accident Related to Auto ____ Work ____ Other _____

Describe How Injury Occured_____

Occupation: _____ Working _____ Off Work _____ Light Duty _____

Referring Doctor: _____ Next Appointment: _____

Reason for Seeking Therapy: (circle all that apply) Sharp Pain Dull/Achy Pain Radiating Pain Tingling Burning

Numbness Weakness Decreased Motion Decreased ability to perform daily activities (list activities below)

1. _____ 2. _____

General Health: Excellent ___ Good ___ Fair ___ Poor ___ Activity Level: High: ___ Med-Hi ___ Med-Low ___ Low ___

Current Medications (please list): 1. _____ 2. _____

3. _____ 4. _____ 5. _____

Allergies: _____

Are you allergic to Latex? Yes _____ No _____ Any previous injuries to this extremity? Yes _____ No _____

Explain: _____

Have you ever had any of the following conditions? (Circle all that apply)

Rheumatoid Arthritis Osteoarthritis Thyroid Problems Multiple Sclerosis Cancer Pacemaker Hepatitis

Tuberculosis High Blood Pressure Heart Problems HIV Positive/AIDS Osteoporosis Diabetes Numbness

Tingling in extremities Neurological Problems Bone/Joint Problems Epilepsy/ Seizures

Other medical problems? _____

Please list any healthcare professionals following your care for this condition (MDs, therapists, chiropractors, personal trainers, acupuncturists, massage therapists):

Name: _____ Phone#: _____

Name: _____ Phone#: _____

Name: _____ Phone#: _____

My signature below acknowledges that the above information is accurate to the best of my knowledge:

Patient signature: _____ Date: _____

Therapists Initials: _____ Therapy Diagnosis: _____