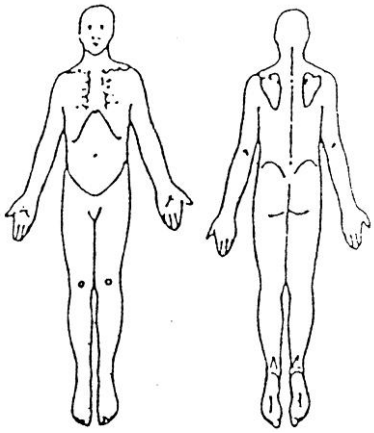
PATIENT HISTORY FORM

DATE_____NAME_____AGE_____

Why are you having Physical Therapy?_____

What are your symptoms? (circle) pain numbness tingling burning weakness other (please explain)_____

(mark problem area below)



Have you had any of the following tests or treatments for your current symptoms? (circle) Xray MRI Injection Physical Therapy

If you were hospitalized for your current symptoms, list dates_____

Are you receiving Home Medical services in your home?_____

Have you been treated for any of the following conditions? (circle) Cancer Cardiac Conditions Diabetes High Blood Pressure
Do you have a Pacemaker?_____
Are you Pregnant?_____

Past Medical History/Orthopedic Surgeries_____
_____

Return date to doctor (if known)? _____

Are you currently working?_____Occupation_____

How long have you been doing this job?_____Employer_____

If you have Medicare or a Medicare replacement plan please fill out the Medications form attached OR provide the receptionist with a list for copying including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

If you are age 65 or older and a Medicare recipient, please answer the following questions: Have you had any falls in the past 12 months?_YES/NO____How many falls_____
Were you injured in any falls?_____
_____

_____

(FOR OFFICE USE ONLY)
DX: