APEX PHYSICAL THERAPY

Patient Medical History Form

Name _____ DOB _____ Date of Evaluation _____

Referring Physician (if applicable) _____ Next MD Appt ____/____/____

Chief Complaint _____ Approximately when did this start? _____

Location of Pain _____

Cause of Symptoms _____

Have you ever injured this region before? ☐ Yes ☐ No If yes, explain: _____

What medical help have you sought for this current problem? ☐ MD ☐ Chiropractor ☐ PT ☐ Dentist ☐ Other

Have you had any of the following for this current problem? ☐ X-Ray ☐ MRI ☐ CT Scan ☐ Bone Scan

Occupation _____ Are you currently working? ☐ Yes ☐ No ☐ Restricted Duty

What activities do you perform during the day (work or home)? _____

Are your symptoms due to a MVA or work injury? ☐ Yes ☐ No If yes, explain: _____

Have you contacted an attorney regarding your symptoms? ☐ Yes ☐ No If so, who: _____

Describe your symptoms (Check all that apply) ☐ Constant ☐ Intermittent ☐ Improving ☐ Worsening ☐ Sharp

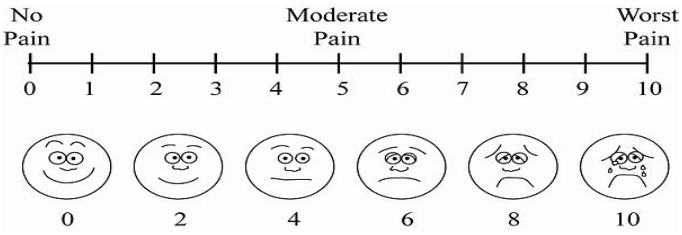
☐ Radiating (travels down arm/leg) ☐ Referred (pain away from original pain site) ☐ Dull ☐ Achy ☐ Throbbing

☐ Disturbs Sleep - please describe _____ ☐ Numbness ☐ Tingling ☐ Burning ☐ Shooting

What aggravates your symptoms? (Check all that apply) ☐ Sitting ☐ Rising from Sitting ☐ Standing ☐ Lifting

☐ Bending ☐ Walking ☐ Running ☐ Stairs ☐ Driving ☐ Squatting ☐ Lying Down ☐ Cough/Sneeze ☐ Stress
☐ Turning Head ☐ Looking Up/Down ☐ Overhead Activities ☐ Dressing/Showering ☐ Other _____

What eases your pain? (Check all that apply) ☐ Rest ☐ Change in position ☐ Cold ☐ Heat ☐ Medication
☐ Other _____



Using the scale to the left, please describe your pain level:

Worst _____ Average _____ Best _____

Please describe your goals for physical therapy _____

Have you had a fall in the past year? ☐ Yes ☐ No How many falls have you had in the past year? _____

Do you use an assistive device for walking? ☐ Yes ☐ No If yes, what do you use? _____

Do you ever get dizzy or lightheaded? ☐ Yes ☐ No If yes, please describe _____

Please list any allergies _____

Do you have a **Pacemaker**, **Pain Pump**, **Spinal Cord Stimulator**, or other electrical implant? ☐ Yes ☐ No

Are you currently pregnant, think you may be pregnant, or trying to become pregnant? ☐ Yes ☐ No

Do you smoke or use tobacco products? ☐ Yes ☐ No If yes, how much per day and how long? _____

If you drink alcohol, about how many drinks do you consume, on average, per week? _____

Have you **recently** noted any of the following? (check all that apply)

☐ Fatigue
☐ Fever/Chills/Sweats
☐ Nausea/Vomiting
☐ Weight Loss/Gain
☐ Numbness or Tingling
☐ Muscle Weakness
☐ Difficulty Swallowing
☐ Constipation
☐ Changes in Bowel/Bladder Function
☐ Diarrhea
☐ Shortness of Breath
☐ Fainting
☐ Cough
☐ Headaches

Have you **ever** been diagnosed with any of the following conditions? (check all that apply)

☐ Cancer
☐ Heart Problems
☐ Chest Pain/Angina
☐ High Blood Pressure
☐ Circulation Problems
☐ Blood Clots
☐ Stroke
☐ Anemia
☐ Bone or Joint Infection
☐ Chemical Dependency
☐ Depression
☐ Lung Problems
☐ Tuberculosis
☐ Asthma
☐ Rheumatoid Arthritis
☐ Other Arthritic Conditions
☐ Bladder/Urinary Tract Infection
☐ Kidney Problems/Infection
☐ STDs/HIV/Hepatitis
☐ Pelvic Inflammatory Disease
☐ Thyroid Problems
☐ Diabetes
☐ Osteoporosis
☐ Multiple Sclerosis
☐ Epilepsy or Seizures
☐ Vision/Eye Problems
☐ Ulcers
☐ Liver Problems
☐ Pneumonia
☐ Other Autoimmune Disorder

Has anyone in your immediate family ever been diagnosed with any of the following? (check all that apply)

☐ Cancer
☐ Heart Problems
☐ High Blood Pressure
☐ Diabetes
☐ Stroke
☐ Blood Clots
☐ Autoimmune Disorders

Please list any medications you are currently taking (If this changes while you are being treated, please inform your PT)

Medication	Dose	How Often?	How is it taken? (by mouth, injection, etc)
1.			
2.			
3.			
4.			

**Please ask front desk if additional lines are required

Please list any surgeries or other conditions for which you have been hospitalized, including dates: _____

_____

During the past month, have you been feeling down, depressed, or hopeless? ☐ Yes ☐ No

Is this something with which you would like help? ☐ Yes ☐ No

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

I do hereby state that the above information is accurate and true to the best of my knowledge

Patient/Guardian Signature _____ Date ____/____/____

Reviewed by Therapist _____ Date ____/____/____