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 ______________________

No Pain — Moderate Pain — Worst Pain

0 1 2 3 4 5 6 7 8 9 10

0 2 4 6 8 10

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 ____/____/____