

PT Plus - Medical History

Patient Name: _____

Date of Birth: ____/____/____

Current Condition (why you are here today))

What Body Part are we treating? _____

When/How did this problem begin? _____

Have you ever had this problem before? Yes/No

What makes the problem worse? _____ Better? _____

Have you had previous treatment or therapy for your current condition? Yes/No

Location: _____ Dates: _____ Number of visits: _____

What are your goals of physical therapy? _____

Are you currently working? Yes/No If no or restricted, please describe: _____

X-Ray/MRI Results _____

Are you currently experiencing any of the following:

Yes/No Fever/chills/sweats

Yes/No Tremors or Seizures

Yes/No Headaches

Yes/No Changes in Vision

Yes/No Fatigue

Yes/No Skin Rash

Yes/No Numbness/Tingling

Yes/No Sexual Difficulties

Yes/No Weakness

Yes/No Changes in Hearing

Yes/No Difficulty breathing

Yes/No Swelling

Yes/No Dizziness

Yes/No Difficulty Swallowing

Yes/No Nausea or vomiting

Yes/No Heartburn/Indigestion

Yes/No Unexplained or dramatic weight loss/gain

Yes/No Constipation/Diarrhea

Yes/No Changes in bowel or bladder function

Yes/No Blood in Stool or Urine

Yes/No Night pain

Yes/No Difficulty Sleeping

Please list any medications, vitamins or supplements that you are currently taking:

Type: _____ Dosage: _____ Reason: _____

Type: _____ Dosage: _____ Reason: _____

Type: _____ Dosage: _____ Reason: _____

Type: _____ Dosage: _____ Reason: _____

Past Medical History

Please list any traumas, surgeries, injuries, or hospitalizations past or present. This includes past motor vehicle accidents, falls, sports injuries, pregnancies/childbirth etc.

Type: _____ Date: _____ Type: _____ Date: _____

Type: _____ Date: _____ Type: _____ Date: _____

Have you ever been diagnosed with any of the following?

Yes/No Allergies

Yes/No Depression

Yes/No Multiple Sclerosis

Yes/No Anemia

Yes/No Diabetes

Yes/No Osteoporosis

Yes/No Anxiety

Yes/No Dizzy Spells

Yes/No Parkinson's

Yes/No Arthritis

Yes/No Emphysema/Bronchitis

Yes/No Rheumatoid Arthritis

Yes/No Asthma

Yes/No Fractures

Yes/No Seizures

Yes/No Cancer

Yes/No Gallbladder Problems

Yes/No Speech Problems

Yes/No Cardiac Conditions

Yes/No Hepatitis

Yes/No Strokes

Yes/No Cardiac Pacemaker

Yes/No High Blood Pressure

Yes/No Thyroid Disease

Yes/No Chemical Dependency

Yes/No Incontinence

Yes/No Tuberculosis

Yes/No Circulation Problems

Yes/No Kidney Problems

Yes/No Vision Problems

Yes/No Currently Pregnant

Yes/No Metal Implants

Yes/No Blood Clots

Have you suffered from any illnesses not listed above? Yes/No If yes, please explain:

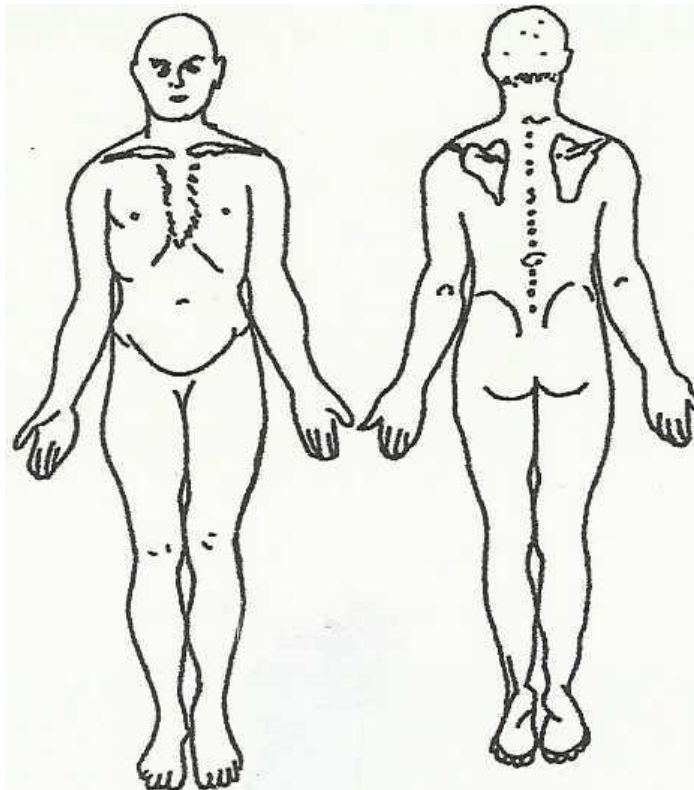
Health and Wellness

Do you have regular check-ups with your physician? Yes/No Last Physical Exam? _____
 Are you under the care of any of the following?
 ___ Medical Doctor ___ Osteopath ___ Dentist ___ Psychiatrist/Psychologist
 ___ Chiropractor ___ Acupuncturist ___ Personal Trainer
 Do you regularly have your skin examined? Yes/No
 Have you had any recent falls? Yes/No
 Have you fallen twice or more in the last year? Yes/No
 Are you pre/post-menopausal? Yes/No
 Tobacco? Yes/No Packs/Day: _____ For how many years? _____ If quit, when? _____
 Alcohol? Yes/No Days/Week: _____ Drinks/Day? _____
 Do you exercise on a regular basis? Yes/No What/How Often? _____
 How would you rate your stress level? Low Medium High

Please let us know if there are other areas of your health that you would like us to address:

Pain Diagram:

Please shade in areas of pain



Pain Scale:

Please indicate the amount of pain you are experiencing

(minor) 1 2 3 4 5 6 7 8 9 10 (worse possible)

Patient: _____
 Date: _____

Therapist: _____
 Date: _____