Church Health

Patient Medical History

Name:_____ Age:____ Date of next Dr's appointment __/___/___
Referring Provider: _____ Diagnosis: _____
Your main concern: _____

Are you presently working? ____Yes _____ No What is/was your Occupation? _____
Employer: _____Phone: _____
Are you currently apply for or filing an appeal for disbility? ___Yes ___No
Was your injury a result of an automobile accident? _____ Yes _____ No
Is the injury work related? _____ Yes _____ No Date of injury: ____/____/____
Is there an attorney involved? _____ Yes _____ No
Are you applying for disability?_____Yes _____No
Are you currently having Home Health? _____ Yes _____ No

Who is your Primary Care Provider: _____When did you last see him/her?____
Please check any of the following whose care you are under: ___ Physical Therapist
__ Chiropractor __ Psychiatrist/Psychologist __ Medical Doctor/Osteopath _ Other:____
Have you, for any reason had out patient physical therapy this calendar year? __Yes__No
If Yes- approximately how many visits? ____

Have you had any of the following tests for THIS condition: (if yes, please list date):
X-Rays_____ MRI_____ CAT scan_____ Bone Scan_____ Nerve/Muscle Test_____ Other_____

Please list any surgeries (in/out patient) and any conditions for which you have been hospitalized and the dates:
_____ ___/___/ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___

Are you currently being treated by a physician for any heart related disorder? __Yes __No
If so, what was the diagnosis? _____
Women: Are you currently pregnant or think you might be pregnant? ___ Yes ___ No

How many days per week do you drink alcohol?_____
If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____
Do you smoke? ___Yes ___No If Yes, how much per day? _____

Have you had a fall in the last year? ___Yes ___ No If Yes, how many _____ Were you injured ?
If yes, please describe: _____

Therapists: if screen indicates potential fall risk, please include in your exam components looking at balance, strength, and gait training/instructions, etc.

Which of the Over-the-Counter medicines have you taken in the last week? Circle all that apply:

Aspirin Tylenol Aleve Antacid Advil/Motrin/Ibuprofen

Antihistamines Decongestants Laxatives Vitamins/Mineral Supplements

Other: Please Specify_____

Please list any PRESCRIPTION medications you are taking (including pills, injections, and/or patches):

1. _____ 2._____ 3._____
4. _____ 5. _____ 6. _____

Have you EVER been diagnosed as having any of the following conditions? Circle all that apply.

Seizures/Epilepsy	Cancer	Diabetes	Vision/Hearing Problems
Headaches	Migraines	Osteoporosis	Urinary/Fecal Incontinence
High Blood Pressure	Heart Problems	Pacemaker	Rheumatoid Arthritis
Hepatitis	Anemia	Tuberculosis	Emphysema/Bronchitis
Stroke/TIAs	Sleeping Problems	Depression	Weight/Energy Loss
Asthma	Dehydration	Parkinson's	Chemical Dependency
Thyroid Problems	Multiple Sclerosis	Gout	Circulation Problems
Orthopedic Surgery	Alzheimer's	Other: _____	

Have you recently noted?:

Weight loss/gain	___Yes ___ No	Weakness	___Yes ___ No
Nauseas/Vomiting	___ Yes ___ No	Fever/chills/sweats	___ Yes ___ No
Dizziness/Lightheadedness	___ Yes ___ No	Numbness or Tingling	___ Yes ___ No
Fatigue	___ Yes ___ No	Night Pain	___ Yes ___ No

Please indicate your goals for physical therapy: _____
_____

Pain Scale- Please rank your pain 0-10 scale. Zero is pain free, 10 is the worst pain.

0 No pain	1	2	3	4	5	6	7	8	9	10 Worst

What aggravates your pain? Please circle all that apply.

Sitting	Standing	Lifting	Rise from sitting	Stairs	Squatting
Dressing	Running	Driving	Looking Up or Down	Stress	Cough/Sneeze
Walking	Laying Down	Bending	Overhead Activity	Turning Head	

Other:_____

What eases your pain? Please circle all that apply.

Rest	Ice	Changing positions
Medications	Heat	Other:_____

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

_____ Date: ___/___/___
Signature of Patient or Guardian

Reviewed by Therapist: _____ Date: ___/___/___