

**ARTHRITIS & SPORTS**  
**PHYSICAL THERAPY**

**Medical History Form**

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

REFERRING PHYSICIAN'S NAME: \_\_\_\_\_

DATE OF ONSET/INJURY \_\_\_\_\_

PRIMARY CARE PHYSICIAN'S NAME: \_\_\_\_\_

ARE YOU PRESENTLY WORKING \_\_\_\_\_

CAUSE OF INJURY /ONSET: \_\_\_\_\_

DATE OF NEXT MD VISIT \_\_\_\_\_

DESCRIBE YOUR GENERAL HEALTH (circle one) EXCELLENT    GOOD    FAIR    POOR

WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH DUE TO INJURY/SURGERY

- 1
- 2
- 3

WHAT ARE YOUR GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY

- 1
- 2
- 3

HAVE YOU RECENTLY BEEN HOSPITALIZED ?    YES    NO    IF YES, WHEN? \_\_\_\_\_

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION?    YES    NO  
WHAT WAS DONE/RESULTS?

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR    YES    NO

IF SO WAS IT AT    HOSPITAL \_\_\_\_\_    OUT PATIENT FACILITY \_\_\_\_\_    HOME HEALTH \_\_\_\_\_

FOR HOW LONG? \_\_\_\_\_

CURRENT MEDICATIONS:

ALLERGIES: \_\_\_\_\_

DO YOU KNOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?(circle all that apply)

ANEMIA	CARDIAC PROBLEMS	HEPATITIS/HIV	PACEMAKER
ARTHRITIS	DEPRESSION	HIGH BLOOD PRESSURE	RESPIRATORY PROBLEMS
ASTHMA	DIABETES	KIDNEY PROBLEMS	SEIZURES
CANCER	DIZZINESS/FAINTING	LOW BLOOD PRESSURE	SUBSTANCE ABUSE
HEADACHES	FRACTURES	METAL IMPLANTS	THYROID PROBLEMS
			CURRENTLY PREGNANT

ANY OTHER MEDICAL PROBLEMS? \_\_\_\_\_

Signature of patient: \_\_\_\_\_ Reviewed by : \_\_\_\_\_