ARTHRITIS & SPORTS PHYSICAL THERAPY

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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 PHYSCIAL 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)

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

ANY OTHER MEDICAL PROBLEMS?____

Signature of patient:____ Reviewed by : ________________________