

# Medical History Form

Patient Name:		Today's Date:	
Referring Physician:		Date of Birth:	Age:
Primary Care Physician:		Are You Presently Working? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Next Physician Appointment:		Date of Injury or Onset:	
Reason for Therapy:			
Cause of Injury or Onset: <input type="checkbox"/> Accident <input type="checkbox"/> Auto <input type="checkbox"/> Work <input type="checkbox"/> Other:      If Other, please explain:			
Have you been hospitalized for the present condition?    Yes <input type="checkbox"/> No      If Yes, date:			
Did you have surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No      If Yes, date: If Yes, surgery type:			
Are you currently receiving any other care for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe:			
Have you ever received therapy in the past for the condition mentioned above? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, date: Describe previous treatment:			
Previous Treatment: <input type="checkbox"/> Successful <input type="checkbox"/> Unsuccessful			
Have you fallen in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No    If Yes, how many times?      If Yes, were you injured? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you feel unsteady when standing or walking? <input type="checkbox"/> Yes <input type="checkbox"/> No      Do you worry about falling? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What are your personal goals/outcomes you hope to achieve from therapy?			
Describe your general health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor		Do you smoke or use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	
DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)			
<input type="checkbox"/> Allergies <input type="checkbox"/> Latex <input type="checkbox"/> Other	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Kidney Problems	
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy or Seizure Disorder	<input type="checkbox"/> Metal Implants	
<input type="checkbox"/> Anxiety or Panic Disorders	<input type="checkbox"/> Fainting	<input type="checkbox"/> MRSA	
<input type="checkbox"/> Arthritis <input type="checkbox"/> OA <input type="checkbox"/> RA	<input type="checkbox"/> Fatigue or Weakness	<input type="checkbox"/> Multiple Sclerosis	
<input type="checkbox"/> Asthma	<input type="checkbox"/> Fever or Chills	<input type="checkbox"/> Nausea / Vomiting	
<input type="checkbox"/> Blood Thinners	<input type="checkbox"/> Fractures	<input type="checkbox"/> Osteoporosis	
<input type="checkbox"/> Bowel or Bladder Disorder	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pacemaker	
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Head Injury or Concussion	<input type="checkbox"/> Parkinson's Disease	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Peripheral Vascular Disease	
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Heart Disease or Heart Attack	<input type="checkbox"/> Respiratory or Breathing Problems	
<input type="checkbox"/> COPD	<input type="checkbox"/> Hepatitis <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Ringing in Ears	
<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Hernia	<input type="checkbox"/> Sexual Dysfunction	
<input type="checkbox"/> Currently Pregnant	<input type="checkbox"/> Blood Pressure <input type="checkbox"/> High <input type="checkbox"/> Low	<input type="checkbox"/> Skin Abnormalities	
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> HIV or AIDS	<input type="checkbox"/> Stroke or TIA	
<input type="checkbox"/> Depression	<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Thyroid Problems	
<input type="checkbox"/> Diabetes <input type="checkbox"/> Type I <input type="checkbox"/> Type II	<input type="checkbox"/> Hypersensitivity to Hot or Cold	<input type="checkbox"/> Tuberculosis	
List any other medical problems and explain:			
Over the Counter Medications (check all that apply): <input type="checkbox"/> Aspirin/Ibuprofen <input type="checkbox"/> Antacids <input type="checkbox"/> Sleeping Aids <input type="checkbox"/> Cold Medicine: <input type="checkbox"/> Cough Medicine <input type="checkbox"/> Allergy Relief <input type="checkbox"/> Laxative <input type="checkbox"/> Diet Pills <input type="checkbox"/> Vitamins/Herbal Supplements <input type="checkbox"/> Other:			

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## Medication List

Name of Medication	Dosage	Frequency	Route
1			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
2			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
3			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
4			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
5			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
6			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
7.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
8.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
9.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
10.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
11.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other
12.			<input type="checkbox"/> Injection <input type="checkbox"/> Oral <input type="checkbox"/> Topical <input type="checkbox"/> Other

<b>Signature of Patient:</b>		
<b>Printed Name of Patient:</b>		<b>Date:</b>
<b>For Staff Use Only</b>		
<b>Weight (lbs):</b>	<b>BMI = <math>\frac{\text{Weight (lbs)}}{[\text{Height (in)} \times \text{Height (in)}]} \times 703</math></b>	<input type="checkbox"/> WNL {BMI = $\geq 18.5$ and $< 25$
<b>Height (in):</b>		<input type="checkbox"/> Above Normal Parameters [BMI $\geq 25$
<b>BMI:</b>		<input type="checkbox"/> Below Normal Parameters [BMI $< 18.5$ ]
<b>Signature of Therapist:</b>		<b>Date:</b>

Revised 2-2022