PERFORMANCE PHYSICAL THERAPY
MEDICAL HISTORY

Name: _____ Date: _____

Date of birth: _____ Occupation: _____

Pertinent medical history: _____

Date of injury/surgery: _____ Referring doctor: _____

Please describe your injury: _____

Type of pain: sharp / aching / burning / numb / tingling / shooting / other: _____

Pain scale (circle a number):

No pain Moderate "The worst pain of my life"

I_____I_____I

0 1 2 3 4 5 6 7 8 9 10

Does your pain radiate? YES / NO If yes, to where? _____

Does rest relieve your pain? YES / NO

Are you currently taking any medications either for the pain or for other conditions? YES / NO

List medications: _____

List activities that INCREASE your pain: _____

List activities that DECREASE your pain: _____

Do you currently have or have you had any of the following?

Diabetes	YES / NO	Kidney Problems	YES / NO
High Blood Pressure	YES / NO	Stroke	YES / NO
Heart Disease	YES / NO	Pregnancy	YES / NO
Pacemaker	YES / NO	Shortness of Breath	YES / NO
Cancer	YES / NO	Allergies	YES / NO
Thyroid Problems	YES / NO	Asthma	YES / NO
Seizures	YES / NO	Skin Disorders	YES / NO
Respiratory Infection	YES / NO	Ulcers	YES / NO
Urinary Tract Infection	YES / NO	Stress	YES / NO
Nausea/Vomiting	YES / NO	Depression	YES / NO
Changes in Appetite	YES / NO	Difficulty Sleeping	YES / NO
Unexplained Weight Loss	YES / NO	Fever/Chills	YES / NO

If yes to any of the above, please describe: _____

I CONFIRM THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO CONFIRM THAT THE PHYSICAL THERAPIST HAS REVIEWED THIS INFORMATION WITH ME AND IS AWARE OF MY PAST MEDICAL HISTORY.

SIGNATURE OF THE PATIENT: _____ DATE: _____

I, THE PHYSICAL THERAPIST, CONFIRM THAT I HAVE REVIEWED THAT INFORMATION PROVIDED BY THE PATIENT ABOVE AND AM AWARE OF HIS/THERAPIST MEDICAL HISTORY.

SIGNATURE OF THE PHYSICAL THERAPIST: _____ DATE: _____