Total Physical Therapy

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PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____/_____/_____

Are you presently working? □ Yes □ No

Date of next physician's visit: _____ /_____ /_____

1. Date of injury/onset: _____/_____/_____

2. Have you ever had these symptoms before? □ Yes □ No

3. Check which apply to your current condition:
   □ work-related injury □ recurrence of previous injury □ motor vehicle accident
   □ injury related to lifting □ injury related to falling □ athletic/recreational
   □ cause unknown □ other: _____ □ injury

4. If female, are you pregnant? □ Yes □ No

5. Do you have, or have had any of the following:

	Yes	No		Yes	No
Diabetes	□	□	Hypoglycemia	□	□
Chest Pain/Angina	□	□	Osteoarthritis	□	□
High Blood Pressure	□	□	Osteoporosis	□	□
Heart Disease	□	□	Hernia	□	□
Heart Attack	□	□	Seizures	□	□
Heart Palpitations	□	□	Metal Implants	□	□
Pacemaker	□	□	Dizziness/Fainting	□	□
Headaches	□	□	Fractures	□	□
Problems Kidney	□	□	Surgeries	□	□
Cancer	□	□	Skin Abnormalities	□	□
Stroke	□	□	Nausea/Vomiting	□	□
Bowel/Bladder Abnormalities	□	□	Ringing in your ears	□	□
Urine Leakage	□	□	Rheumatic Arthritis	□	□
Asthma/Breathing Difficulties	□	□	Smoking	□	□
Liver/Gallbladder Problems	□	□	Other	□	□

If you answered Yes to any of the items above, please briefly explain and give the date. Include any other pertinent information regarding your past medical history.

_____

_____

_____

6. Do you have any allergies? □ Yes □ No

If yes, please list your allergies:

_____

_____

_____

7. Are you presently taking any medications? □ Yes □ No

If yes, please list what medications and for what condition:

Medication	Dosage

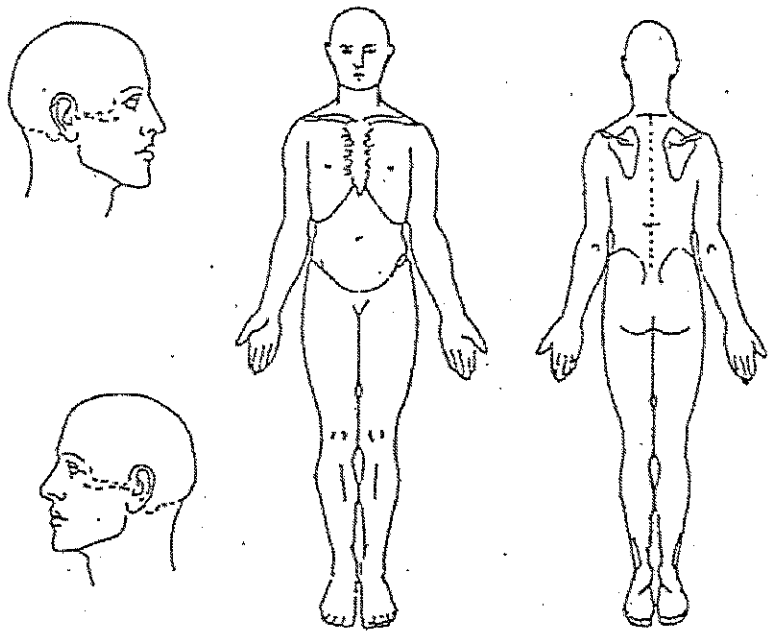
8. Do you participate in any sports, exercise programs or activities on a regular basis? □ Yes □ No

9. Have you had a related surgery? □Yes □ No

If yes, please list them below

Surgery	Date

11. Please indicate below where your symptoms are located



12. If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible. Circle one.

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Consent to Treatment

I understand that I have been referred for rehabilitative treatment and care to Total Physical Therapy Rehabilitation Center. I understand that I have the right to ask and have any questions answered prior to receiving any treatment; including any risks or alternatives to the treatment plan. By signing this agreement, I consent to have Total Physical Therapy & Rehabilitation provide treatment and care as prescribed by my physician and/or recommended by my therapist.

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

Relationship to Patient _____
(parent, guardian, spouse, etc.)