DISTINCT
PHYSICAL THERAPY

Medical History Form

Date:_____

Patient Name:_____ Date of Birth: _____ Age:_____

Are you presently working? _____ Next Doctor visit: _____

Diagnosis/Chief Complaint: _____

Height:_____ Weight:_____

1. Date of Injury/Onset:_____ 2. Have you ever had these symtpoms before? _____ Yes _____No

3. Check which apply to your current condition:

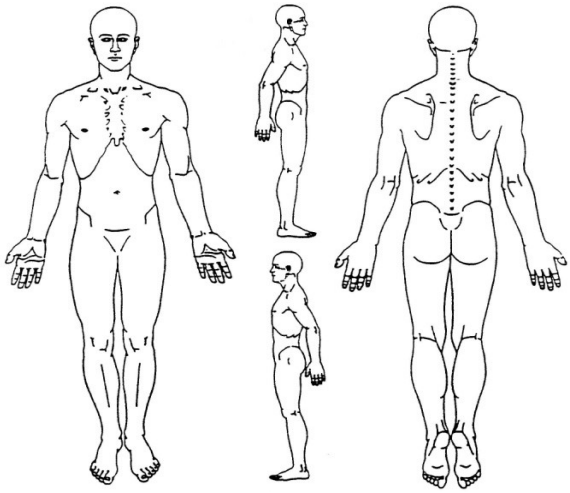
___Motor Vehicle Accident ___Work Related ___Recurrence of Previous Injury
___Cause Unknown ___Injury Related to Lifting ___Athletic/Recreational
___Injury Related to Falling ___Two or more falls in the last year ___Other:_____

4. Have you had a related surgery? _____Yes _____No Date:_____
5. Have you had any other surgeries? _____Yes _____No

Explain: _____

6. If female, are you pregnant? _____Yes _____ No

7. Please indicate below where your symptoms are located:



Key:
Numbness: XXXXXXXXXXXXXXX
Pins & Needles: OOOOOOOOO
Burning Pain: ////////////////////
Stabbing Pain: ++++++++++++++++

8. 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:
Pain at best: ____/10 Pain at worst:____/10

9. How and when did your injury occur or how and when did your symptoms begin:_____

_____

_____

_____

_____

10. Do you participate in any sports, exercise programs or activities on a regular basis? ____Yes ____No

11. Do you have or have you had any of the following?

Heart Disease

Congestive Heart Failure	____Yes____No	Valvular Disease	____Yes____No
High Blood Pressure	____Yes____No	Stents	____Yes____No
Heart Attack	____Yes____No	Arrhythmia	____Yes____No
Atherosclerotic isease	____Yes____No	Coronary Artery Bypass Graft	____Yes____No
Angioplasty	____Yes____No	Angina	____Yes____No
Pacemaker	____Yes____No		

Lung Disease

Chronic Obstructive Pulmonary Disease	____Yes____No	Asthma	____Yes____No
Emphysema	____Yes____No	Recent Pneumonia	____Yes____No

Vascular Disease

Peripheral Arterial Disease	____Yes____No	Stroke/TIA	____Yes____No
Diabetes	____Yes____No	Chronic Bronchitis	____Yes____No
Taking Blood Pressure Medication	____Yes____No	Hypertension	____Yes____No
Acquired Respiratory Distress Syndrome	____Yes____No		

General Medical Conditions

Rheumatoid Arthritis	____Yes____No	Degenerative Disc Disease	____Yes____No
Osteoarthritis	____Yes____No	Hepatitis	____Yes____No
Allergies	____Yes____No	AIDS	____Yes____No
Neurological Disease	____Yes____No	Osteoporosis	____Yes____No
Headaches	____Yes____No	Anxiety	____Yes____No
Gastrointestinal Disease	____Yes____No	Panic Disorder	____Yes____No
Hernia	____Yes____No	Depression	____Yes____No
Ulcer	____Yes____No	Previous Accidents	____Yes____No
Reflux Problems	____Yes____No	Kidney Problems	____Yes____No
Bowel Abnormalities	____Yes____No	Prostate Problems	____Yes____No
Liver Problems	____Yes____No	Incontinence	____Yes____No
Gall Bladder Problems	____Yes____No	Hearing Impairment	____Yes____No
Vision Problems	____Yes____No	Sleep Dysfunction	____Yes____No
Dizziness/Fainting	____Yes____No	Prosthetic Implants	____Yes____No
Fractures	____Yes____No	Cancer	____Yes____No
Hypoglycemia	____Yes____No	Seizures	____Yes____No
Skin Abnormalities	____Yes____No	Metal Implants	____Yes____No
Smoking	____Yes____No		

If you sad YES to any of the above items, please brienfly explain and give corresponding dates. Include any other pertinent information regarding your past medical history.

_____

_____

_____

_____

12. Are you currently any medication? ____Yes____No

If YES, please list:

_____

_____

_____

Patient Signature:_____ **Date:**_____

Parent/Guardian Signature:_____ **Date:**_____

Therapist Signature:_____ **Date:**_____