**Past Medical History Form**

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| **PATIENT INFORMATION** | **PHYSICIAN INFORMATION** |
| Patient Name: | Primary Physician: |
| Date of Birth: | Marital Status: | Referring Physician: |
| **CONTACT INFORMATION** |
| Phone: | Occupation: | Emergency Contact/Phone: |
| Address: | City/State: | Zip: |
| **CURRENT INJURY:** |
| Chief Complaint: |
| Onset: ⎕Sudden ⎕Gradual | Injury: ⎕ No Injury ⎕ Auto ⎕Work ⎕Other |
| If injured, briefly describe how injury occurred: |
| Any loss of sensation with current problem? ⎕ Yes ⎕ No | Can you get comfortable at night? ⎕ Yes ⎕No | Height:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Have you had a similar problem before? ⎕Yes ⎕No | If yes, how long ago? |
| Have you ever had physical or occupational therapy for this similar problem? ⎕Yes ⎕ No | If yes, what type of treatment did you receive? |
|  |
| Do you have pain related to your current problem? ⎕ Yes ⎕ No | Where is the pain? (Mark diagram below using the “key”) |
| What activities/positions decrease your pain? | pain-drawing 6inch**KEY****|| Numbness****00 Pain****XX Tingling** |
| What activities does pain interfere with or prevent you from doing? |
| Has the pain spread? ⎕ Yes ⎕ No | If yes, where? |
|  |
| Describe your pain/symptoms: (check if applicable)⎕ Stays all the time ⎕Throbbing ⎕Dull ⎕Burning ⎕ Comes and goes ⎕ Shooting ⎕ Numbness ⎕ Sharp ⎕ Tingling ⎕ Pricking ⎕ Pressure ⎕ Aching ⎕ Heavy⎕ Gnawing |
| What activities/positions increase your pain? |
| Please rate your pain/comfort level using scale to the right: | C:\Users\Jason\AppData\Local\Microsoft\Windows\INetCache\Content.Word\wong_baker.gif | What is your goal for pain relief using the same scale? |
| Have you sought medical help for current problem? ⎕ Doctor ⎕Chiropractor ⎕ Physical Therapy ⎕ Occupational Therapy |
| Have you had any x-rays/MRIs to diagnose above problem? ⎕ Yes ⎕ No If yes, when and results? |
| List any surgeries: | List any allergies: |
| **DO YOU HAVE ANY OF THE FOLLOWING?** |
| Asthma, Bronchitis, or Emphysema  | ⎕ YES ⎕ NO | Poor Circulation  | ⎕ YES ⎕ NO |
| Shortness of Breath/Chest Pain  | ⎕ YES ⎕ NO | Irregular Heartbeat | ⎕ YES ⎕ NO |
| Coronary Heart Disease  | ⎕ YES ⎕ NO | Low Blood Pressure | ⎕ YES ⎕ NO |
| Pacemaker  | ⎕ YES ⎕ NO | Rapid Heartbeat | ⎕ YES ⎕ NO |
| High Blood Pressure  | ⎕ YES ⎕ NO | Swelling of ankles | ⎕ YES ⎕ NO |
| Heart Attack/Surgery  | ⎕ YES ⎕ NO | Nausea/Stomach Pain | ⎕ YES ⎕ NO |
| Stroke/TIA  | ⎕ YES ⎕ NO | Vomiting  | ⎕ YES ⎕ NO |
| Blood Clot/Emboli  | ⎕ YES ⎕ NO | Depression | ⎕ YES ⎕ NO |
| Epilepsy/Seizures | ⎕ YES ⎕ NO | Forgetfulness | ⎕ YES ⎕ NO |
| Thyroid Trouble/Goiter | ⎕ YES ⎕ NO | Excessive Thirst/Hunger | ⎕ YES ⎕ NO |
| Anemia  | ⎕ YES ⎕ NO | Fever | ⎕ YES ⎕ NO |
| Infectious Disease  | ⎕ YES ⎕ NO | Appetite Poor | ⎕ YES ⎕ NO |
| Diabetes | ⎕ YES ⎕ NO | Weight Gain/Loss | ⎕ YES ⎕ NO |
| Cancer or Chemo/Radiation  | ⎕ YES ⎕ NO | Nervousness | ⎕ YES ⎕ NO |
| Arthritis/Swollen Joints | ⎕ YES ⎕ NO | Chills/Sweats | ⎕ YES ⎕ NO |
| Osteoporosis | ⎕ YES ⎕ NO | Pain/Weakness/Numbness in: |
| Varicose Veins  | ⎕ YES ⎕ NO | Back | ⎕ YES ⎕ NO |
| Gout | ⎕ YES ⎕ NO | Feet | ⎕ YES ⎕ NO |
| Loss of Sleep | ⎕ YES ⎕ NO | Hands | ⎕ YES ⎕ NO |
| Emotional/Psychological Problems | ⎕ YES ⎕ NO | Hips | ⎕ YES ⎕ NO |
| Bowel or Bladder Problems | ⎕ YES ⎕ NO | Legs | ⎕ YES ⎕ NO |
| Severe/Frequent Headaches | ⎕ YES ⎕ NO | Neck | ⎕ YES ⎕ NO |
| Vision/Hearing Difficulties | ⎕ YES ⎕ NO | Shoulders | ⎕ YES ⎕ NO |
| Dizziness or Faintness | ⎕ YES ⎕ NO | Arms | ⎕ YES ⎕ NO |
| Are you pregnant? | ⎕ YES ⎕ NO | Sports? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Exercise | ⎕ Daily ⎕ Weekly | Recreational Activites? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Smoking | ⎕ Daily ⎕ Weekly | Other Medical Conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Alcohol Consumption | ⎕ Daily ⎕ Weekly | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| LIST ANY AND ALL MEDICATIONS, NAME/DOSE/FREQUENCY: (Please include Prescription, Over-the-Counter, Herbal, and Vitamin/Mineral/Dietary Supplements)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Are you aware of your Diagnosis? | ⎕ YES ⎕ NO | Are you aware of your Prognosis? | ⎕ YES ⎕ NO |

**Patient/Parent/Guardian Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_