

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BIRTHDATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAST MEDICAL HISTORY

**Current complaint/limitation:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**When did this begin?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did this begin?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you had physical therapy in the past?** If yes, where, when and for what condition?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Are you currently receiving Home Health Services? □Yes □No**

**Please circle if you have any of the following:**

High blood pressure Osteoarthritis Diabetes Allergies

Heart condition Rheumatoid arthritis Dizziness/Vertigo HIV/AIDS

Pacemaker Lupus Implants Tobacco use

Currently pregnant Fibromyalgia Surgeries Alcohol use

Stroke Seizures Cancer Illicit substance use

COPD/Asthma

**If yes to any of the above, please provide details**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

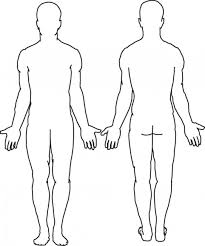
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**Medications? Please provide a copy or enter here**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Recent diagnostic testing?**

X-ray □Yes □No MRI □Yes □No CT scan □Yes □No

Other testing\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please indicate on the diagram:**

**Pain = X Burning = O Area of concern=** ◊

**Cramping = ^ Numbness/Tingling = /**

**Pain rating:**\_\_\_\_\_\_\_\_\_\_\_\_\_ (0 = no pain, 10 = max pain)

Patient/Responsible Party Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_