

Patient Medical History

Are you presently working? **Yes** **No**

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

2. Because of your problem, what specific activities are you having difficulty with?

- 1. _____
- 2. _____
- 3. _____

3. Have you had surgery for this injury/diagnosis? **Yes** **No**

If so, please list date: _____

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

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Allergies to Aspirin |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Allergies to heat |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies/Poor tolerance to cold |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Dizziness/Fainting |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Recent Fractures |
| <input type="checkbox"/> Pregnant | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Skin Abnormalities |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Nausea/Vomiting |
| <input type="checkbox"/> Bowel/Bladder Abnormalities | <input type="checkbox"/> Urine Leakage |
| <input type="checkbox"/> Ringing in your ears | <input type="checkbox"/> Asthma/Breathing Difficulties |
| <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Liver/Gallbladder Problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Smoking |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Other: _____ |

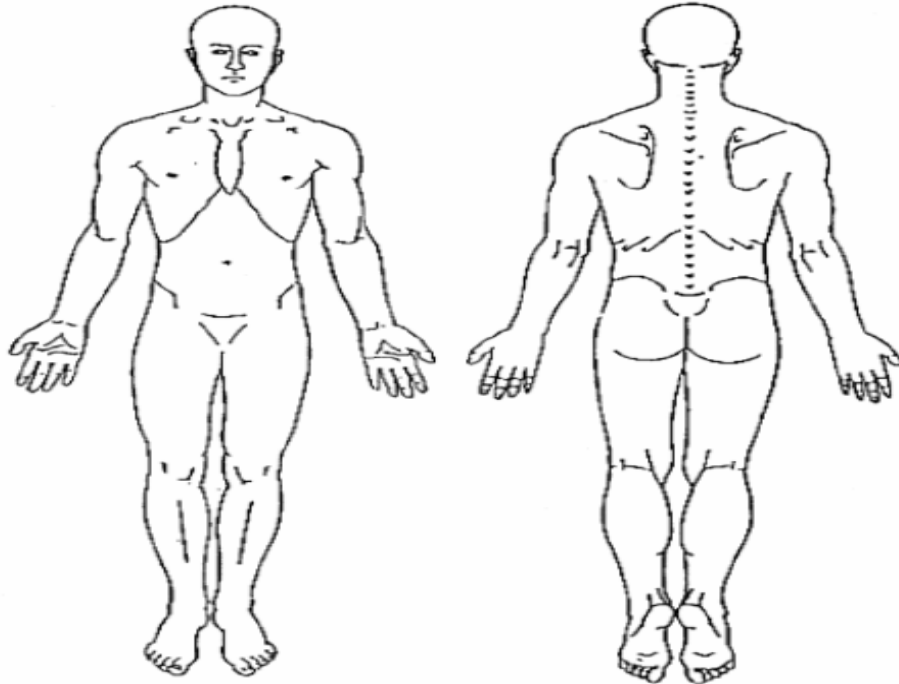
If any of the above checked, please briefly explain and give approximate dates.

5. Please list all current medications: _____

Medical History Continued

6. Do you participate in any exercise programs, or activities on a regular basis? **Yes** **No**

7. Please indicate below where your symptoms are located:



8. 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. _____

Please use the scale below to establish your level of pain:

- 0 No pain
- 1 Mild pain; you are aware of it, but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication
- 4-5 More severe pain; you begin to feel antisocial
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain; it may make you contemplate suicide

Patient/Guardian Signature

Date

Therapist Signature

Date