

# Patient Medical History



Name \_\_\_\_\_ Date \_\_\_\_\_

Please explain the nature of the problem you are seeing us for today.  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Was this problem a result of injury?  Yes  No  
If yes, what was your functional status prior to your injury?  
\_\_\_\_\_  
\_\_\_\_\_

Have you had or do you have any of the following?

- |                     |  |                           |  |
|---------------------|--|---------------------------|--|
| Diabetes            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Dizziness                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hernia              | <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| High Blood Pressure | <input type="checkbox"/> Yes <input type="checkbox"/> No | Metal Implants            | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Seizures            | <input type="checkbox"/> Yes <input type="checkbox"/> No | Chronic Headaches         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Heart Disease       | <input type="checkbox"/> Yes <input type="checkbox"/> No | Previous Physical Therapy | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Previous Surgery    | <input type="checkbox"/> Yes <input type="checkbox"/> No | Currently Pregnant        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker           | <input type="checkbox"/> Yes <input type="checkbox"/> No |                           |  |

If you answered yes to any of the above questions please explain and give the date of occurrence.  
\_\_\_\_\_  
\_\_\_\_\_

Do you have a latex allergy?  Yes  No

What medications are you currently taking? \_\_\_\_\_

Have you had any injections?  Yes  No  
If yes, where? \_\_\_\_\_

Have you had any X-Rays, MRI, etc.?  Yes  No  
If yes, for what area? \_\_\_\_\_

Please circle on the scale below your level of pain today.  
**0** = No pain    **10** = Pain that would make you go to the emergency room

**1   2   3   4   5   6   7   8   9   10**

Please indicate on the drawing the location(s) of your pain:

