Crossroads PHYSICAL THERAPY, P.C. *Where Recovery Begins*

PATIENT MEDICAL HISTORY

Name _____ Date _____ Next Physician Appointment _____

Please explain the nature of the problem you are seeing us for today, and the approximate date the problem started.

_____

_____

Was this problem a result of injury? Yes No
Have you had a recent flare-up or increase in your symptoms? Yes No
Have you had a recent decline in your ability to function? Yes No
Have you fallen in the past year? Yes No Number of falls: _____ Resulted in an injury? Yes No
What are you unable to do now as a result of your problem?

_____

What was your functional status prior to your problem?

_____

What is your goal or what do you want to be able to do when you have finished therapy?

_____

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

Diabetes	Yes	No	Previous Surgery	Yes	No
Hernia	Yes	No	Chronic Headaches	Yes	No
Previous Physical Therapy	Yes	No	Pacemaker	Yes	No
High Blood Pressure	Yes	No	Dizziness	Yes	No
Seizures	Yes	No	Currently Pregnant	Yes	No
Chiropractic Intervention	Yes	No	Cancer	Yes	No
Heart Disease	Yes	No	Metal Implants	Yes	No
Massage Therapy	Yes	No	Allergic to Latex	Yes	No
Home Health Care	Yes	No	Allergies	Yes	No
Osteoporosis/Osteopenia	Yes	No	Arthritis	Yes	No
Neurological Disorders	Yes	No	Stroke	Yes	No
Blood Clot	Yes	No			

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

_____

_____

What medications are you currently taking? (or provide a list for us to photo copy)

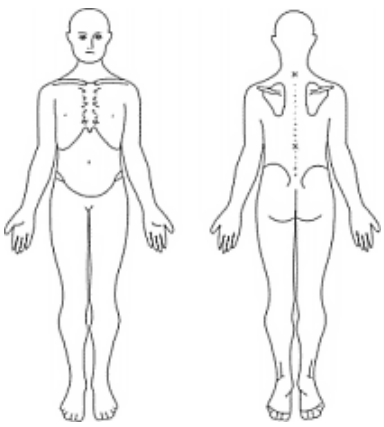
_____

_____

Have you had any injections? Yes No If yes, what type, what area, and did they help?

_____

Have you had any X-Rays, MRI, CT scan, etc.? Yes No
If yes, for what area? _____
When and where were the images taken? _____
_____



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: