THE BODY SHOP
physical therapy

PHYSICAL THERAPY MEDICAL HISTORY

Today's Date: _____/_____/_____
Month Day Year

PATIENT INFORMATION:

Name: (First) _____ (Middle Initial) _____ (Last) _____

Date of Injury/Onset: _____

Describe how the Injury Occurred: _____
_____

MEDICAL HISTORY:

	Yes	No		Yes	No
Diabetes			Allergies to Heat/Cold		
Chest Pain/Angina			Other Allergies		
High Blood Pressure			Hernia		
Heart Disease			Seizures		
Heart Attack			Metal Implants		
Heart Palpitations			Dizziness/Fainting		
Pacemaker			Fractures/Broken Bones		
Headaches			Surgeries		
Kidney Problems			Skin Abnormalities		
Are you Pregnant			Sexual Dysfunction		
Cancer			Nausea/Vomiting		
Osteoporosis			Ringing in your Ears		
Bowel/Bladder Issues			Arthritis		
Urine Leakage			Special Diet Guidelines		
Asthma/Breathing Difficulties			Hypoglycemia		
Liver/Gall Bladder Problems			Epilepsy		
Do you smoke?			Eye Problems		
Stroke/CVA			Depression		
Allergies to any Medication			Other:		

If "yes" to any of the above, please explain and provide approximate dates:

_____
_____
_____

Is there any other information, regarding your health history, that we should know about?

_____

_____

_____

Are you currently taking prescriptive medication, supplements or herbal remedy for any conditions at this time?

_____

_____

Do you exercise? If so, what type of exercise do you participate in and how often do you do it?

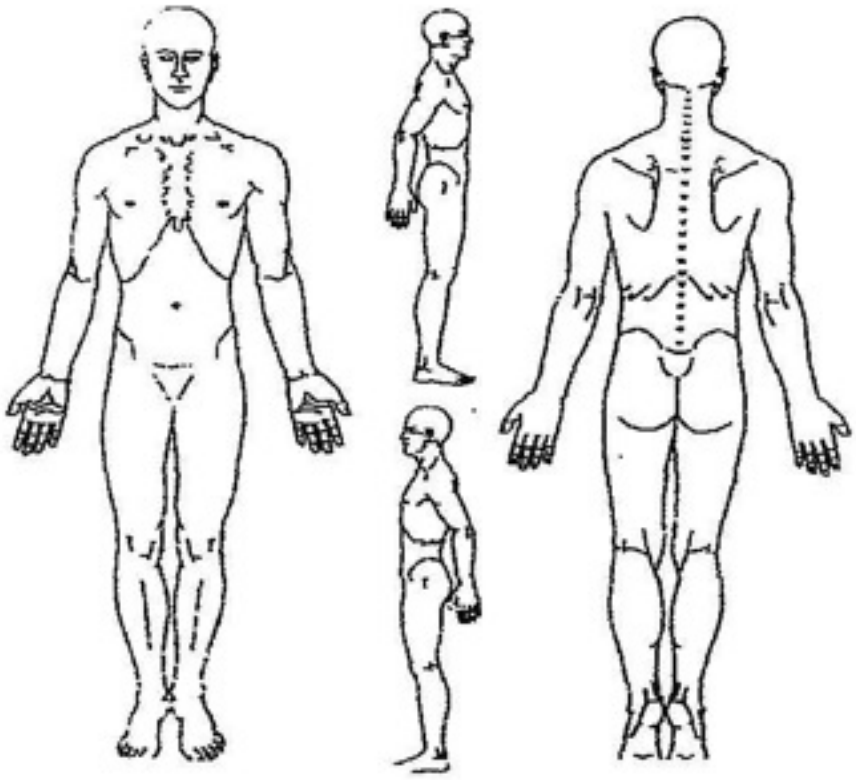
_____

_____

_____

CURRENT SYMPTOMS:

	Yes	No		Yes	No
Chest Pain			Hearing Problems		
Coordination Problems			Loss of Balance		
Decrease Range of Motion			Pain at Night		
Difficulty Concentrating			Vertigo/Dizziness		
Difficulty Sleeping			Weakness		
Headaches			Other:		



Legend Key

Numbness NNNNNNNNNN

Pins & Needles 000000000000

Burning Pain XXXXXXXXXX

Stabbing Pain SSSSSSSSSS

Please mark the area of concern and identify the type of feeling experienced there:

Please grade your pain on a scale of 0 to 10 and 10 being the worse possible pain

_____

Duration of Symptoms: (This episode)_____

What makes the symptoms:

Worse? _____

Better? _____

SIGNATURES:

_____ _____/_____/_____

Patient's Signature-age 18 or older Month Day Year

_____ _____/_____/_____

Parent or Guardian Signature (if minor) Month Day Year

_____ _____/_____/_____

Therapist Signature Month Day Year