ALLIED PHYSICAL THERAPY
MEDICAL HISTORY

NAME _____ DATE OF BIRTH___/___/____ TODAYS DATE ___/___/____

PRIMARY CARE PROVIDER_____ SPECIALIST_____

WHAT ARE WE SEEING YOU FOR?_____

_____

DATE OF INJURY _____ DATE OF SURGERY _____
HEIGHT _____ WEIGHT _____ AGE _____

PAIN: Circle the phrase that best describes your current level of pain.

0	1	2	3	4	5	6	7	8	9	10
No Pain (0)	Mild Pain		Moderate Pain		Severe Pain		Extreme Pain		Worst Pain Imaginable	

LOCATION OF PAIN_____ WHEN DID IT START?_____

HAVE YOU SEEN ANY OTHER MEDICAL PROVIDERS FOR THIS PROBLEM? YES / NO
If YES: Primary Care Provider /Specialist / PT / OT / Chiropractor / Other_____

IS THIS WORK RELATED? YES / NO **MOTOR VEHICLE ACCIDENT?** YES / NO
On a separate sheet, please describe the details of your accident.

PREVIOUS PHYSICAL THERAPY: YES / NO **If YES, Where**_____ **When**_____

RELATED SURGERY _____DATE_____

OTHER SURGERIES_____ DATE_____

HAVE YOU FALLEN IN THE PAST 12 MONTHS? YES/NO If yes, did you injure yourself? YES/NO If yes, How did you fall?

_____

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PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING CONDITIONS:

___ALLERGY	___HEMOPHILIA	___OSTEOPOROSIS
___ANEMIA	___HEPATITIS	___PACEMAKER
___CANCER	___HERNIA	___PREGNANCY
___ARRHYTHMIA	___HIGH BLOOD PRESSURE	___CLAUSTROPHOBIA
___HIV/AIDS	___RECENT FRACTURES	___DIABETES
___HYPOGLYCEMIA	___RECENT WEIGHT LOSS	___DIZZINESS
___INCONTINENCE	___ RHEUMATOID ARTHRITIS	___FEVER
___KIDNEY DISEASE	___SEIZURES	___GERD
___LUNG PROBLEMS	___SKIN SENSITIVITIES	___HEADACHES
___METAL IMPLANTS	___STROKE	___HEART ATTACK/FAILURE
___NERVOUS DISORDER	___THROMBOPHLEBITIS	___HEART DISEASE
___OPEN WOUNDS	___HEART MURMUR	___OSTEO-ARTHRITIS

Have you ever had any serious illness not listed above? _____YES _____NO
If yes, please explain:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or to the patient's) health. It is my responsibility to inform Allied Physical Therapy of any changes in my medical status.

SIGNATURE OF PATIENT,
PARENT, OR GUARDIAN: **DATE:**