

MEDICAL HISTORY FORM

1. Name: _____

2. Employment Homemaker Disabled
 Work Outside Home Retired

Occupation: _____

3. Do you live alone? Yes No

4. Do you have assistance daily or as needed?

Daily As needed None

5. Medications: Prescription(s) Yes No

If yes please list: _____

Do you currently take **non-prescription** medications?

Ibuprofen/Naproxen Aspirin/Tylenol

Herbal supplement Vitamins/Other

6. Please describe the current problem you are here for? _____

7. What is the primary thing you can not do because of this problem? _____

8. Have you had surgery related to today's visit?

Yes No

If yes, please describe and include dates: _____

9. Are you seeing any other doctor or health practitioner for this current problem?

Yes No

If yes, type of practioner : _____

10. Rate pain with problem between 0 and 10

(0=No pain and 10=Emergency Room)

_____/10

11. Have you been treated for this problem in the past? Yes No

If yes: Type of treatment _____

Result of treatment: Resolved, Partially Resolved, Not Resolved, Worsened with Treatment

(Please circle one of the above)

12. Please check if you have had OR take medication for:

Allergies: Type: _____

Arthritis Rheumatoid Osteoarthritis

Bowel/Bladder Problems Broken Bones/Fracture

Cancer: Type: _____

Depression

Diabetes or problems with blood sugar

Controlled Yes No

With Diet Medication Insulin

Fibromyalgia

Head Injury

Heart problems/Heart Attack

Bypass Surgery

High Blood Pressure

Controlled by Medication Yes No

Infectious Diseases (such as tuberculosis, hepatitis, HIV)

Kidney Problems

Liver problems

Lung problems (asthma, COPD, Emphysema, shortness of breath)

Metal implants

Neurological problems (such as stroke, Parkinson's disease, multiple sclerosis, muscular dystrophy, polio)

Osteoporosis

Seizures/Epilepsy

Sensitivity to latex rubber

Thyroid problems (hyper/hypo/other)

Ulcers/stomach problems

Other not listed above _____

13. MEN:

Prostate disease

WOMEN:

Gynecological Issues

Please list _____

14. Are you currently or have you received Home Care services or Skilled Nursing Facility Services? Yes No

Patient Signature: _____

Date: / /

Therapist Signature: _____

Date: / /