MTS PHYSICAL THERAPY & WELLNESS

MEDICAL HISTORY FORM (Please Print Clearly)

Patient Name DOB Date Completed

Referring Physician Return Date to Physician

Are you receiving home health? Yes / No *If yes, Agency Name Phone #

(PLEASE NOTE: If you are a Medicare patient and you are receiving home health, Medicare will not pay for you to have outpatient PT & home health at the same time, please let the receptionist know immediately if this applies to you)

What caused you to seek physical therapy/medical attention?

Your condition is related to (circle) Employment / Auto Accident / Home / Other

*If Other, please explain

Date of condition/accident State Accident Occurred

What is your major compliant? (Please be as detailed as possible)

Have you had this problem before? Yes / No

If you have pain, what is your pain level?
(0= No Pain, 10 = Extreme Pain – Circle)

AT WORST (circle) 0 1 2 3 4 5 6 7 8 9 10

AT BEST (circle) 0 1 2 3 4 5 6 7 8 9 10

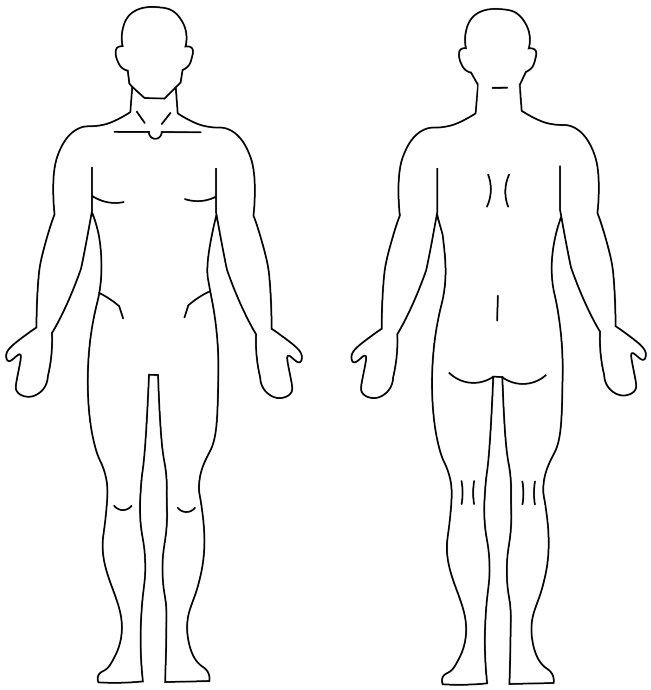
Currently (circle) 0 1 2 3 4 5 6 7 8 9 10

Are your symptoms

- ☐ Constant
- ☐ Come & Go
- ☐ Ache
- ☐ Deep
- ☐ Superficial
- ☐ Dull
- ☐ Sharp
- ☐ Shooting
- ☐ Burning
- ☐ Numbness/Tingling

Other:

Mark location of your pain with an "X" (below)



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MEDICAL HISTORY FORM CONTINUED (Please Print Clearly)

Does your pain seem to be WORSE at a certain time of day? Yes / No If Yes, Morning / Night / Other

Does your pain progress as the day goes along? Yes / No If Yes, please explain

Do you have difficulty falling asleep? Yes / No If Yes, please explain

Do you wake due to pain? Yes / No If Yes, # of times per night

What were you doing prior to this injury that you are unable to do currently?

- ☐ Squatting
- ☐ Sitting
- ☐ Driving
- ☐ Reaching
- ☐ Work Tasks
- ☐ Holding/Carrying Objects
- ☐ Lifting
- ☐ Walking
- ☐ Burning
- ☐ Gripping/Pinching
- ☐ Dressing/Grooming
- ☐ Stairs
- ☐ Position Change
- ☐ Kneeling
- ☐ Standing

Other:

What were you doing prior to this injury that you are unable to do currently?

- ☐ Cooking
- ☐ Cleaning
- ☐ Vacuuming
- ☐ Laundry
- ☐ Yard Work
- ☐ Grocery Shopping

Other:

Do you use an assistive device? (circle) No / Cane / Walker / Wheelchair / Other

Do you use an assistive device prior to current injury/condition? (circle) Yes / No

What activities make your pain better?

What activities make your pain worse?

Is this pain getting (circle) Better / Worse / Not Changing

What type of treatments have you received for this condition?

- ☐ X-Rays
- ☐ Surgery
- ☐ Chiropractic
- ☐ MRI
- ☐ Medications
- ☐ Injections
- ☐ Bone Scan
- ☐ CT/CAT Scan
- ☐ Physical Therapy
- ☐ Home Health

Please describe (agency, etc.):

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MEDICAL HISTORY FORM CONTINUED (Please Print Clearly)

Have you fallen in the last 12 months? Yes / No If yes, how many times?

Did your fall result in any injury? Yes / No Explain

Please **check** problems diagnosed by a doctor. **Circle** if you are currently being treated.

☐ Arthritis	☐ Bursitis	☐ Gout	☐ Stroke
☐ Carpal Tunnel Syn.	☐ Anxiety Attacks	☐ Lupus	☐ Epilepsy
☐ Bronchitis	☐ Pneumonia	☐ Osteoporosis/Penia	☐ Sciatica
☐ Abnormal Chest X-ray	☐ Lung Disease	☐ Implants	☐ Diabetes
☐ Emphysema/COPD	☐ Chronic Fatigue Syndrome	☐ Tuberculosis	☐ Asthma
☐ TMJ Dysfunction	☐ Dizziness/Fainting Spells	☐ Gout	☐ Heart Disease
☐ Fibromyalgia	☐ Ulcer/Colitis/Diverticulitis	☐ Migraine Headaches	☐ Blood Thinner
☐ High Blood Pressure	☐ Low Blood Pressure	☐ Rheumatoid Arthritis	☐ Immunosuppression
☐ Thrombosis/Phlebitis	☐ Muscular Dystrophy	☐ Pregnant – Due Date: _____	

☐ Disc Problem (circle) – slipped / herniated / bulging

☐ Blood-Borne Pathologies (circle) – HIV / AIDS / Hepatitis A / Hepatitis B / Hepatitis C

☐ Tumors / Cancer – Year Type Remission: Yes / No

☐ Infection / Inflammation – What? Where?

☐ Heart Disease – What type: Pacemaker: Yes / No Date Rec'd

☐ Sprains / Dislocations / Broken Bone – Please list & where:

Please list all medications you are currently taking and what they are for [Specific name of medication, dosage, frequency & Route (Example: by mouth), please include over the counter, prescriptions, herbals & vitamins):

Please list any previous surgeries:

Height Weight