FREEHOLD PHYSICAL THERAPY
PATIENT MEDICAL HISTORY FORM

Name: ____________________________ DOB:______________ Date: ________________

To help us better evaluate your condition please complete this form to the best of your knowledge. If you have any questions please ask for assistance. Thank you.

MEDICAL HISTORY: (please check any condition you have a history of. Items not checked are understood to be negative.)

___ High/Low Blood Pressure
___ Chronic Lung Problem
___ Abnormal Heart Rate
___ Heart Problem
___ Abnormal Bleeding
____ Hepatitis
___ Shortness of breath
___ Heart Palpitations
___ Seizures/Epilepsy
___ Circulatory Condition
___ Cancer
___ Arthritis
___ Asthma
___ Emphysema
___ Pacemaker
___ Diabetes
___ Osteoporosis
___ Dizziness

Other:____

Do you have a history of fractures? YES NO Where? ____
Do you have a history of back/neck pain? YES NO When? _____________________________________
Do you have any metal implants? YES NO Where? ____
Do you exercise regularly? YES NO How often? ____
Do you have any known allergies? YES NO Please list ____
Are you allergic to latex? YES NO
Are you pregnant or suspect pregnancy? YES NO

MEDICATIONS: Please check if you are taking any of the following (Please list name of medications)

___ Blood Pressure Medication
___ Muscle Relaxants
___ Steroids (Cortisone)
___ Heart Medication
___ Pain Killers
___ Anti-inflammatories
___ Anti-coagulants (blood thinners)
___ Diabetes Medication (i.e.Insulin)
___ Other Medications

SURGERIES: Please list all surgeries, including date:
____
____
____

DIAGNOSTIC TESTS: Please check test(s) for current problem only.

( )X-rays ( )CT scan ( )MRI ( )Bone Scan ( )EMG ( )Bone Density

( )Blood Chemistry ( )Ultrasound ( )Other (please specify)_________________________

Have you seen anyone else for your current problem?

( )Physician/MD ( )Chiropractor ( )Podiatrist ( )Orthopedic Surgeon ( )Dentist

( )Neurologist/Neurosurgeon ( )Osteopath/DO ( )Physical Therapist Date:

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CHIEF COMPLAINT/ CURRENT CONDITIONS:
Date condition started ___________________

Please describe what happened and what hurts: ____
____
____
____

SYMPTOMS: In regards to your current condition:

Do you have any "pins and needles" or numbness in your extremities? YES NO
Do you have any weakness in your arms or legs? YES NO
Do you have any coordination or balance problems? YES NO
Do you have difficulty walking? YES NO
Do you experience dizziness or vertigo with a change in position? YES NO
Have you experienced headaches as a result of your condition? YES NO
Have you had this problem before? YES NO

Circle the area on the drawing where you have pain

FRONT BACK

Please rate your pain in this scale of 0-10.

0 1 2 3 4 5 6 7 8 9 10

no pain severe pain

What makes your pain better ________________________________
____

What makes your pain worse ________________________________
____

I believe all information to be true and complete:

Signature__________________________ Date:___________