

Medical History Form

1. Name _____ 2. Sex Male Female
3. Height _____ Weight _____ 4. Date of Birth: ____/____/____ 5. Occupation _____
6. Do you have any customs or religious beliefs that might affect your care? Yes No

If yes, please describe: _____

7. Describe the problem(s) for which you seek physical therapy:

8. When did this problem(s) begin? Date: ____/____/____

What happened? _____

9. Have you ever had this problem(s) before? Yes No If yes, when: _____

How did you treat this before? _____

10. What makes the problem(s) feel better?

11. What makes the problem(s) feel worse?

12. What are your goals for physical therapy?

13. Do you exercise on a regular basis? Yes No

If yes, what activities and how often? _____

14. Do you have family members who have or had any of the following conditions?

	Relationship to you		Relationship to you
Heart Disease		Cancer	
Hypertension		Arthritis	
Stroke		Osteoporosis	
Diabetes		Other	

15. Have you ever had surgery? Yes No If yes, when: _____

For what injury/condition(s)? _____

16. Have you had any previous fractures? Yes No If yes, when: _____

What body part(s)? _____

17. Do you have any metal plates, screws, or other devices (pacemaker, etc.) surgically implanted? Yes No

If yes, please describe: _____

18. Do you take any medication(s) on a regular basis? Yes No

If yes, please list: _____

19. Do you have any other conditions which you think might be relevant for today's evaluation?
