Medical History Form

Name:_____

Age:_____ Height:_____ Weight:_____ Male [ ] Female [ ]

Chief Complaint/Reason for Today's Visit:_____

Occupation:_____ Primary Care Physician: _____

Activities done at work: (ex: sitting, lifting, standing, computer work):

_____

What is your pain level in the last week? Best_____ Worst_____ Current_____ (0-10, ten being severe pain)

Where is your pain? _____

Do you have or have you had any of the following:

	Yes	No	Details		Yes	No	Details
Diabetes				Metal Implants Including Joint Replacement			
High Blood Pressure				Difficulty Breathing			
Heart Disease/Attack				Headaches			
Pacemaker				History of Smoking			
Stroke				Seizures			
Cancer				Broken Bones			
Kidney Problems				Previous Surgeries			
Osteoporosis				Arthritis, Osteoarthritis or Rheumatoid			

If yes to any of the above, please explain as necessary:

_____

In the present calendar year, have you received any of the following:

Outpatient Physical/Occupational Therapy/Chiropractic/Acupuncture Care? Yes [ ] No [ ]

If Yes, Which type of Treatment:_____ and how many sessions: _____

Are you pregnant or is there a chance you could be pregnant? _____

Have you fallen in the last year? _____

Did it result in injury? _____ If So, what?_____

Current Medications and Dosage: _____

_____

Who referred you to Pearl Physical Therapy P.C._____

Patient Signature:_____ Date:_____