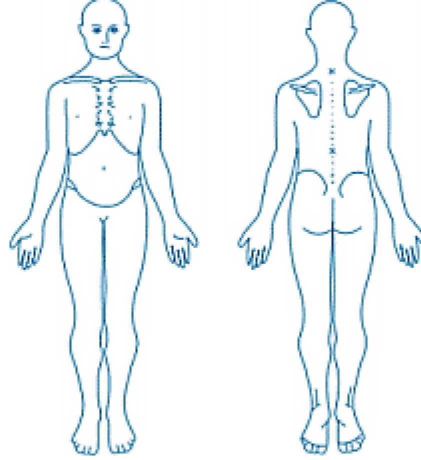
Patient Medical History Profile

Name____ Current Weight: ______ / Height:________

Date of injury or date symptoms began ________________________

Mark the location of your symptoms.



Briefly describe your injury:_________________________________

____

Are your symptoms constant or intermittent? ______________________

Pain Level: (0-10) _____ 0=No Pain, 5=Moderate Pain, 10=Worst Pain

Since onset of symptoms, have they become: Worse Better Same

Have you had surgery for your condition? Yes_______ No_______

Is there one movement or position that will produce/increase your symptoms?

____

What treatments have you had for this current problem? ____

Do you have a history of any of the following: ____Cancer If yes, what kind? _____________________________________

____Pacemaker	____Anemia	____Epilepsy	____Head Injuries
____Broken Bones	____Arthritis	____ Car accident	____Coordination
____Heart Disease	____Headaches	____Generalized Weakness	____Difficulty Walking
____High blood pressure	____Stroke	____Muscular Disease	____Dizziness
____Joint Problems	____Diabetes	____Neck Injuries	
____Lung Disease	____Back Injuries	____M.S./ Neurological Disease	

Are you taking any medications presently? No_____ Yes____ if yes, (please provide list with the names, frequency and dosage)

Have you had a fall in the last 12 months? No _____ Yes_____ If yes, how many falls? _____ Did the fall result in injury? Y / N

Allergies: ____

Do you have any pain or discomfort with any of the following activities?

Sleeping____ Dressing____ Sitting____ Standing____ Walking____ Housework____ Driving____ Stairs____

Sporting Activities____ Yard work____

What goals do you want to achieve with therapy?

____

____