FYZICAL®
Therapy & Balance Centers

MEDICAL HISTORY

Name:_____
Date of Birth: _____ Age:___ Gender: M / F
Height(ft):_____(in)_____ Weight: ____lbs
Hand Dominance:_____
Date of Injury:_____

Date of Surgery:___/___/____Type of Surgery:
(That you are here for today)_____
Occupation: _____
School(If student now):_____
Sports/Hobbies: _____

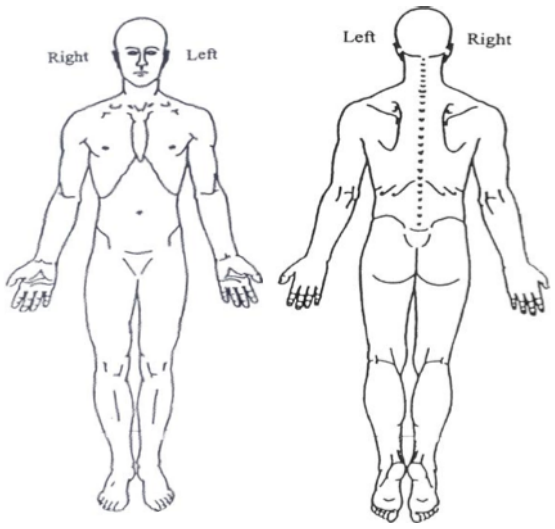
Have you had any Imaging? (Please Circle All That Apply) X-ray/Bone Scan/MRI/CT Scan /Other

Please Identify your Problem Area on the Diagram.
Since it started, pain is: (Circle One)

Getting Worse Improving The Same

Describe your pain: ? (Check all that apply)

___Sharp ___Dullness ___Aching
___Burning ___Throbbing ___Shooting
___Cramping ___Stabbing Other:_____



Changes in Bowel and Bladder Function? Yes / No

Difficulty with Cough/Sneeze/or Straining? Yes / No

Do you have any Tingling, Numbness or Loss of Skin Sensation? Yes / No If so, Where?-Show on diagram with T(Tingling) and/or N(Numbness)

Do wake from sleep due to pain? Yes / No

Check any activities you have difficulty with due to the problem you are seeking treatment:

___Sleeping	___Rolling in Bed	___In/Out of Bed	___In/Out of Chair
___Driving	___Walking	___Standing	___Stairs
___Dressing	___Bathing	___Self Care	___Reaching Overhead
___Lifting	___Exercise	___House Work	___Sitting (>45 min)

Others NOT listed:_____

Is there anything that makes you feel better/Reduces your pain?_____
_____

Rate your pain on 0-10 scale (0 is no pain, 10 is the worst you can imagine). Please Circle.

Pain Right Now: 0 1 2 3 4 5 6 7 8 9 10

Pain at Best: 0 1 2 3 4 5 6 7 8 9 10

Pain at Worst: 0 1 2 3 4 5 6 7 8 9 10

Home Environment (circle all that apply): Live alone/independent Live w/spouse/partner

Assisted living Child/Adolescent-lives with parents Steps/Stairs involved

Work Environment: Retired Part time labor Part time desk work

Full time Labor Full time desk work Stairs/Steps involved

Please list ALL Medications/Supplements/Vitamins you are taking: (OR give list to front office)

_____

_____

Please list ALL other previous Surgeries and dates: (OR give list to front office)

_____

_____

How would you rate your Current Health?(Circle One) Excellent / Very Good / Good /Fair / Poor

Do you have problems with (Circle all that Apply): Hearing - Vision - Communication - None

Are you Currently: Pregnant? Yes / No **Stressed?** Yes / No **Anxious/Depressed?** Yes / No

Do you participate in any of the following? ___Smoke/Chew Tobacco Packs per Day: _____

___Drink Alcoholic Beverages Amount per Day: ____

Please check if you have any of the following conditions:

___Acid Reflux or Ulcer
___Angina/Chest Pain
___Anxiety
___Asthma
___Bleeding Disorder
___Cardiac Bypass
___Cardiac Stents
___Cancer (Site: _____)
___Consistent Steroidal Medicine Use
___COPD
___Depression
___Diabetes (Type 1 or 2)
___Dizziness or Fainting
___Emphysema
___Headaches or Migraines
___Heart Attack
___High Blood Pressure
___High Cholesterol
___Kidney Disease
___Metal/Plastic Implants
___Nausea
___Osteoarthritis
___Osteoporosis or Osteopenia
___Recent Infection
___Recent Anticoagulant Medicine Use
___Rheumatoid Arthritis
___Seizures/Epileps
___Sexually Transmitted Disease
___Stroke
___Thyroid Disorder

In the past 3 months have you experienced any of the following?

___Changes in hearing
___Changes in mental abilities
___Frequent or severe headaches
___Swallowing or changes in speech
___Changes in vision
___Problems w/ balance, coordination or

falling
___Fainting spells
___Persistent pain at night
___Fevers, chills or night sweats
___Unexplained weight loss
___Unwarranted fatigue
___Unusual lumps or growths
___Pulsating pain anywhere in your body
___Constant and severe pain in leg or arm
___Swelling without a history of injury
___Shortness of breath
___Frequent or severe abdominal pain
___Frequent nausea or vomiting

What are your Goals for Physical Therapy?_____