New Patient Medical History

Name: ________________________________ Date of Birth:______________________

Height: ________________ Weight:____________ Dominant Hand: R L

Have you received a doctor's referral to physical therapy for this injury or condition?

Yes No

IF "Yes", please provide referring physician information below.

Name:__________________________ Phone #:___________________________

Prescription Date:____

IF "No", please be sure to fill out the Direct Access Notice separately.

Please tell us about your current injury or exacerbation.

When did symptoms start? ____

Describe how the injury occured_______________________________________

Diagnosis as stated by your physician_____________________________________

Describe where the current issue is located:________________________________

Have you received any previous treatment for this injury (Diagnostic tests, another form of therapy, surgery, etc.)? If yes, please describe and provide dates:

____

____

____

___

Please check any of the below symptoms that you are experiencing:

☐ Pain

- ☐ Radiating Up / Down
- ☐ Tenderness
- ☐ Numbness / Tingling
- ☐ Aching
- ☐ Throbbing
- ☐ Burning
- ☐ Other: ____________________

☐ Dizziness / Imbalance

- ☐ Vertigo / Room-spinning
- ☐ Lightheadedness
- ☐ Imbalance
- ☐Other:___________________

My pain / symptoms are worse…..

In the morning   During the day   At night   With activity   At rest

Symptoms come and go   Symptoms are constant

My pain / symptoms are better….

In the morning   During the day   At night   With activity   At rest

Symptoms come and go   Symptoms are constant

Place marks on lines to indicate your level of pain/ symptoms

Please rate your CURRENT level of pain or symptoms on the line below:

____

0 1 2 3 4 5 6 7 8 9 10

Please rate your BEST level of pain or symptoms on the line below

____

0 1 2 3 4 5 6 7 8 9 10

Please rate your WORST level of pain or symptoms on the line below

____

0 1 2 3 4 5 6 7 8 9 10

Have you fallen in the past year? Yes No How many times?________

IF "Yes", have you injured yourself in any fall?________________________________

Do you feel unsteady when standing or walking?______________________________

Do you worry about falling?____

Please check any of the conditions listed below that you have been or are presently being treated for. This information helps your therapist develop the treatment plan that will be best for you.

☐ Acquired Respiratory Distress Syndrome

☐ Allergies

☐ Angina

☐ Anxiety or Panic Disorders

☐ Arthritis

☐ Asthma

☐ Back Injury

☐ Bleeding Disorders

☐ Bowel / Bladder Abnormalities

☐ Cancer

☐ Chronic Obstructive Pulmonary Disease

☐ Congestive Heart Failure

☐ Defibrillator

☐ Degenerative disc Disease

☐ Depression

☐ Diabetes

☐ Dizzy or Fainting Spells

☐ Emphysema

☐ Epilepsy or Seizure Disorder

☐ Fracture

☐ Headaches

☐ Hearing Impairment

☐ Heart Attack

☐ Hepatitis (A, B, C)

☐ Hernia

☐ High Blood Pressure

☐ HIV/ AIDS

☐ Hypoglycemia

☐ Immunosuppressive Condition or Medication

☐ Joint Swelling

☐ Kidney Problems

☐ Liver / Gallbladder Problems

☐ Metal Implants

☐ Multiple Sclerosis (MS)

☐ Nausea / Vomiting

☐ Osteoporosis

☐ Pacemaker

☐ Parkinson's Disease (PD)

☐ Peripheral Vascular Disease

☐ Pregnancy

☐ Recent night Pain / Fever / Sweats

☐ Ringing in the ears

☐ Sexual Dysfunction

☐ Shortness of Breath

☐ Skin Abnormalities

☐ Sleep Problems

☐ Smoking

☐ Special Diet Guidelines

☐ Stroke or TIA

☐ Tuberculosis

☐ Unintentional Weight Change

☐ Upper Gastrointestinal Disease

☐ Visual Impairment

Please list any current medications. A current medication list can also be included on a separate sheet, if needed.

Medication   Reason for Taking   Dosage

____
_

____
_

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Therapy & Balance Centers

____
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What are your goals for Physical Therapy at this time?

1.____

2.____

3.____

Is there any other information you would like your Physical Therapist to know about you at this time?

I have reviewed the above information, and I agree that it is accurate and current.

____
____

Patient Signature Date