Southwest Sport & Spine Center, Inc. est. 2000
"Powerful results to get you BACK into action."
Gets
FYZICAL Therapy & Balance Centers

# MEDICAL HISTORY

Patient Name: _____ DOB: _____ Case # _____

**Is your visit related to a Motor Vehicle Accident YES NO Workers Compensation Injury? YES NO**

Reason for visit: _____ Date of injury: _____

Are you latex sensitive? Yes No Other Allergies: _____

List any medication(s) you are allergic to and what the reaction is: _____

Are you Vaccinated for COVID-19 Yes No Date of Initial Injection_____ Type_____ Booster_____

Which of the following OVER THE COUNTER MEDICATIONS have you taken in the last week?

YES NO Advil/Motrin/Ibuprofen
YES NO Antacid
YES NO Antihistamines
YES NO Aspirin
YES NO Decongestants
YES NO Laxatives
YES NO Tylenol
YES NO Vitamins/Minerals/Supplements
YES NO **Vitamins D**

**THERAPIST USE ONLY:**

**Reviewed By: _____ Date: _____**

List all other supplements/medications you are currently taking (all prescribed meds including pills, injections, and/or skin patches) Provide a copy of your list if you have one containing:

1) Name: _____ Dosage: _____ Frequency: _____ Reason: _____
2) Name: _____ Dosage: _____ Frequency: _____ Reason: _____
3) Name: _____ Dosage: _____ Frequency: _____ Reason: _____
4) Name: _____ Dosage: _____ Frequency: _____ Reason: _____
5) Name: _____ Dosage: _____ Frequency: _____ Reason: _____

Have you **EVER** been diagnosed as having any of the following conditions?

YES NO Anemia
YES NO Asthma/COPD Medication? YES NO
YES NO Cancer Type: _____
YES NO Chemical Dependency (ie alcoholism)
YES NO Depression/Mental Disorder
YES NO Cortisone Injections When?_____
YES NO Stroke/TIA When: _____
YES NO Thyroid Problems Medication? YES NO
YES NO Tuberculosis
YES NO Diabetes Type _____ Medication? YES NO
YES NO COVID-19 When? _____
YES NO Arthritis Conditions
YES NO Osteoporosis
YES NO Joint Replacement Which? _____
YES NO Multiple Sclerosis
YES NO Nervous System Disorder
YES NO High Blood Pressure Medication? YES NO
YES NO Circulation Problems/ DVT
YES NO Epilepsy / Seizures Medication? YES NO
YES NO Heart Disease (Including Pacemaker/ICD)
YES NO Hepatitis
YES NO Open Wounds
YES NO Kidney Problems
YES NO Urinary or Fecal Incontinence

Have you recently noted:

YES NO Weight Loss/Gain
YES NO Nausea/Vomiting/Diarrhea
YES NO Sleep Loss
YES NO Fatigue
YES NO Falls With Injury YES NO
YES NO Weakness
YES NO Fever/Chills/Sweats
YES NO Numbness or Tingling
YES NO Lack of Coordination
YES NO Circulation Problems

**MEDICAL HX (CONT.)**

Please list any surgeries, significant injuries, or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization: (Please include any internal devices or modifications)

_____

_____

_____

Date of last PCP visit: _____ Primary Care Provider: _____

Are you currently under the care of:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| YES | NO | Medical Doctor **(MC Required)** | YES | NO | Psychiatrist | YES | NO | Physical Therapist |
| YES | NO | Osteopath | YES | NO | Psychologist | YES | NO | Cardiologist |
| YES | NO | Dentist | YES | NO | Chiropractor | YES | NO | Neurologist |

Other(s): _____

If you have seen any of the above providers in the past three months, Why? _____

Date of last Bone Density (DEXA) scan: _____Where? _____

How many days per week do you drink alcohol? _____Type? _____ How much? _____

How much caffeine do you consume per day? _____ Type? _____

How much nicotine do you use a day? _____ Type? _____

During the past month have you been feeling down, depressed, or hopeless? YES NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Has anyone in your immediate family (parents, brother, sister) ever been treated for any of the following?

| | | | | | |
|---|---|---|---|---|---|
| YES | NO | Anemia | YES | NO | Headaches/Migraines |
| YES | NO | Arthritis Conditions | YES | NO | Heart Disease (Including Pacemaker) |
| YES | NO | Cancer | YES | NO | High Blood Pressure |
| YES | NO | Chemical Dependency (ie alcoholism) | YES | NO | Kidney Disease |
| YES | NO | Diabetes | YES | NO | Mental Disorder |
| YES | NO | Epilepsy / Seizures | YES | NO | Stroke |

**FOR WOMEN** Are you currently pregnant or think you might be pregnant? YES NO

**Have you received HOME HEALTH CARE (ANY CARE AT HOME) in the last 12 months ? YES NO**
**IF YES, WHEN?_____ WHERE?_____WERE YOU DISCHARGED? YES NO**

**Have you had Rehabilitation Therapy in the past 12 months? YES NO Where?_____**

**Concerning the condition for which you were referred for therapy, have you had a recent:**

**MRI: YES NO X-RAY: YES NO CAT SCAN: YES NO WHERE?_____**

I certify that the information above is true and correct to best of my knowledge. I will inform my provider of any pertinent changes.

_____ _____

Patient/Legal Guardian- Representative Date