

## Medical Information

### General Information

Name \_\_\_\_\_ Age \_\_\_\_\_ Gender M F  
Referring Provider (e.g. Doctor, PA-C) \_\_\_\_\_  
Who can we thank for telling you about us? \_\_\_\_\_  
Are you a previous patient? Y N

### History

Occupation \_\_\_\_\_  
Are you currently working? Y N Hours per week \_\_\_\_\_  
Handedness R L Tobacco Use Y N Amount/day \_\_\_\_\_  
Are you pregnant? Y N Are there other pertinent health or prior medical issues we should know about? \_\_\_\_\_

### Past Medical History (Please circle and provide dates and information)

Diabetes/hypo/hyperglycemia \_\_\_\_\_  
High/low blood pressure \_\_\_\_\_  
Cancer \_\_\_\_\_  
Stroke \_\_\_\_\_  
Osteoporosis \_\_\_\_\_  
Osteo/rheumatoid arthritis \_\_\_\_\_  
Broken bones \_\_\_\_\_  
Surgeries \_\_\_\_\_  
Vision/hearing problems \_\_\_\_\_  
Dizziness/fainting/seizures \_\_\_\_\_  
Heart condition/pacemaker \_\_\_\_\_  
Injury to head, chest, organs \_\_\_\_\_  
Depression \_\_\_\_\_  
Mental condition \_\_\_\_\_  
Lung disorders \_\_\_\_\_  
Asthma/difficulty breathing \_\_\_\_\_  
Swelling/joint pain \_\_\_\_\_  
Headaches \_\_\_\_\_  
Night pain \_\_\_\_\_  
Severe illness \_\_\_\_\_  
Other \_\_\_\_\_  
Medications (list) \_\_\_\_\_

## History of Your Current Condition

What are we treating you for? \_\_\_\_\_

When did it start? \_\_\_\_\_

How did it happen? \_\_\_\_\_

Has anything helped? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

Medical tests (X-rays, MRI, etc.) \_\_\_\_\_

Have you had physical therapy before? \_\_\_\_\_

Rate your pain (0-10)    Now \_\_\_\_\_    Worst \_\_\_\_\_    Best \_\_\_\_\_

Rate your ability to do things (1-100%) \_\_\_\_\_

Recreational activities \_\_\_\_\_

## Please mark your pain symptoms below.

(A: Ache    S: Stabbing    R: Radiating    P: Pins and Needles    O: Other)

