MEDICAL HISTORY FORM

Integrative Physical Therapy

Name:		Date:	

Reason for today's visit:

Goals for treatment:

When did the symptoms first occur?	
Is your injury/condition related to (check one):	☐ Job ☐ Car ☐ Home ☐ Other: _____
Do you have pain?	☐ Yes ☐ No ☐ Constant ☐ Intermittent
Where is your pain?	
Does your injury/condition interfere with any of the following (check all that apply):	☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Select two numbers to indicate the range of your pain. Select a low range & high range.	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐7 ☐ 8 ☐ 9 ☐ 10
	No Pain = 1 ---------- Severe Pain = 10
Type of pain (please check all that apply:	☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other _____

Please check the box that applies to your current condition ***(Numbness/Tingling = N/T, Pain = P, Stiffness = S)***

N/T	P	S			NK¢	P	S	
☐	☐	☐	Arm/ Hand Activity		☐	☐	☐	Lying on Back
☐	☐	☐	Pinching/Grasping		☐	☐	☐	Lying on Stomach
☐	☐	☐	Jumping		☐	☐	☐	Lying on R Side
☐	☐	☐	Bending		☐	☐	☐	Sitting
☐	☐	☐	Reaching		☐	☐	☐	Standing
☐	☐	☐	Computer Use		☐	☐	☐	Walking
☐	☐	☐	Squatting		☐	☐	☐	Walking on Uneven Ground
☐	☐	☐	Ascending Stairs		☐	☐	☐	Work Activities
☐	☐	☐	Descending Stairs		☐	☐	☐	Overhead Activity
☐	☐	☐	Driving		☐	☐	☐	Kneeling
☐	☐	☐	Lying on L Side		☐	☐	☐	

HEALTH HISTORY

Please check if you have been diagnosed with the following conditions:

☐ Anemia	☐ Other Arthritic Conditions	☐ Pacemaker
☐ Asthma	☐ Emphysema/Bronchitis	☐ Rheumatoid Arthritis
☐ Cancer Type: _____	☐ Epilepsy/Other Seizures	☐ Stroke
☐ Chemical Dependency	☐ Headaches	☐ Thyroid Problems
☐ Circulation Problems	☐ Heart Problems	☐ Tuberculosis
☐ Diabetes	☐ High Blood Pressure	
☐ Depression	☐ Kidney Disease	
☐ Dizziness	☐ Multiple Sclerosis	

Exercise	Work Activity	Habits	
☐ None	☐ Sitting	☐ Smoking	Packs/Day
☐Regular	☐ Standing	☐Alcohol	Drinks/Week
☐Daily	☐ Light Labor	☐Coffee/Soda	Cups/Day
☐Intense	☐ Heavy Labor	☐High Stress Level	Reason

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		
Hospitalizations		
Other		

Prescription Medications you are currently taking

Over The Counter Medications you take

Have you had any of the following diagnostic testing?	☐ Bone Scan ☐ CT Scan ☐ Doppler Studies ☐ EMG/Nerve Conduction Velocity ☐ MRI ☐ X-Rays

SUBMIT PRINT

If you would like to Print a copy, do it before pressing Submit.
When you submit, your form will be transmitted to Integrative Physical Therapy. If you get a popup, click "Allow" to give permission for the submission to proceed. After the transmission, this PDF will automatically close.