## Heritage Health and Physical Therapy LLC

## MEDICAL HISTORY FORM

Name _____ Date _____

Do you have any of the following conditions? Please check all that apply:

- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Chest pain
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy/seizures
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Heart disease
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Osteoporosis/osteopenia
- ☐ Pacemaker
- ☐ Pregnancy
- ☐ Stroke/TIA
- ☐ Tuberculosis

Do you currently have any of the following symptoms? Please check all that apply:

- ☐ Balance changes
- ☐ Chest pain
- ☐ Coughing up blood
- ☐ Fevers/chills
- ☐ Incontinent bowel
- ☐ Incontinent bladder
- ☐ Nausea/vomiting
- ☐ Night sweats
- ☐ Productive cough
- ☐ Rash or skin changes
- ☐ Trouble breathing
- ☐ Unexplained weight loss
- ☐ Visual changes

Date of injury/onset _____

How did injury occur? _____

Hospitalized? If yes, dates: _____

Surgery? If yes, date: _____

Diagnostic tests? Please list: _____

Previous treatment? Please list: _____

Medications? Please list: _____

**OVER >>**

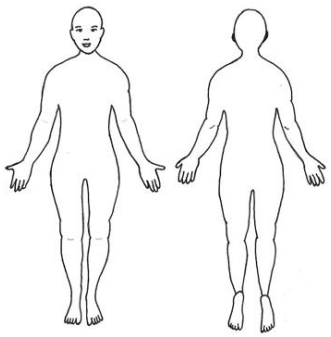
Height:_____ Weight: _____

How would you rate your pain level? Please circle a **LOW** and **HIGH** ranking:

0 1 2 3 4 5 6 7 8 9 10

Pain free Mild Moderate Severe

Please illustrate where you are having current symptoms:



Pain XXX Numbness === Pins/Needles 000

What increases your pain? _____

_____

What decreases your pain? _____

_____

Are you unable to perform certain activities? Please list: _____

_____

Do you participate in any recreation, sports or exercise activities? _____

_____

Patient Signature: _____ Date: _____

PT Signature: _____ Date: _____

Revised: March 2014