MotionWorks physical therapy

Medical History Form

Name: ____
Date of Birth: ____________ Age: _____ Height: ______________ Weight: ____________
Occupation: ________________________ Marital Status: ________________________

To ensure you receive a complete and thorough evaluation, please provide us with important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

YOUR MEDICAL HISTORY

YES NO Osteoarthritis Location: ______________________________
YES NO Rheumatoid Arthritis
YES NO Gout
YES NO Shingles
YES NO Osteoporosis or Osteopenia
YES NO Cancer Location: ______________________________
YES NO Skin disorders Type: ______________________________
YES NO Depression
YES NO Anxiety
YES NO Psychiatric Disorders Type: ______________________________
YES NO High blood pressure
YES NO Blood or clotting disorders
YES NO Anemia
YES NO High cholesterol
YES NO Diabetes
YES NO Stroke
YES NO Heart problems Explain: ______________________________
YES NO Circulation problems Explain: ______________________________
YES NO Blood clot or DVT
YES NO Organ Transplant Type: ______________________________
YES NO Thyroid problems
YES NO Fracture Location: ______________________________
YES NO Headaches
YES NO Concussion
YES NO Seizures/epilepsy
YES NO Multiple Sclerosis
YES NO Parkinson's
YES NO Alzheimer's/Dementia
YES NO Hepatitis
YES NO Tuberculosis
YES NO Kidney disease
YES NO Asthma/Emphysema/Bronchitis
YES NO Chemical dependency Type: ______________________________
YES NO Other ______________________________

IMMEDIATE FAMILY HISTORY (parents, siblings, children)

YES NO Cancer
YES NO Heart disease
YES NO Arthritis
YES NO Stroke

Have you recently noted:

YES NO Unexplained weight loss or gain
YES NO Nausea or vomiting
YES NO Fever/chills/sweats
YES NO Dizziness/lightheadedness/fainting
YES NO Weakness
YES NO Fatigue
YES NO Numbness/tingling
YES NO Recent head injury

Please list any surgical procedures/hospitalizations you have had with the approximate date.

Date	Procedure/Reason for hospitalization
__________	____
__________	____
__________	____
__________	____
__________	____
__________	____
__________	____
__________	____
__________	____

MEDICATIONS/ALLERGIES

Please list the prescription medications you are currently taking, including pills, injections, ointments, and skin patches.

____

____

____

____

Which of the following over the counter medications have you taken in the past week?

YES NO Aspirin

YES NO Antacid

YES NO Tylenol

YES NO Advil/Motrin/Ibuprofen

YES NO Vitamins/supplements (please list): ________________________________

____

Please list the medications you are allergic to: ________________________________

____

Are you latex sensitive? YES NO

List any other allergies we should know about: ________________________________

____

Have you declared an Advanced Clinical Directive of Do Not Resuscitate? YES NO

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

During the past month have you noticed little interest or pleasure in doing things? YES NO

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

Have you fallen in the past year? YES NO If yes, how many times? ________

Did you sustain an injury as a result of one or more of the falls? YES NO

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

How many caffeinated beverages do you drink per day? ________

How many packs of cigarettes do you smoke per day? ________

How many days per week do you drink alcohol? ________

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? ________

Leisure Activities: ____

What is your music listening preference to promote relaxation? ________________________

Please check if you are currently under the care of the following:

_____ Medical doctor (MD or DO)

_____ Chiropractor

_____ Dentist

_____ Psychiatrist/Psychologist

_____ Physical therapist

_____ Other: ____________________________

If you have seen any of the providers listed above in the past 3 months, please describe the reason:

____

____

____ ____

Patient/Guardian signature Date Therapist signature Date