VILLAGE
PHYSICAL THERAPY
PATIENT MEDICAL HISTORY

Patient Name: _____
Age: _____

When did this condition begin? _____

How did symptoms begin? If there was an injury, please explain:

_____

_____

_____

1. Which applies to your condition?

☐ Motor Vehicle Accident ☐ Work Related Injury ☐ Athletic/Recreational Injury
☐ Lifting Injury ☐ Cause Unknown ☐ Other: _____

2. Are you currently working? ☐ Yes Occupation: _____ ☐ No ☐ Retired

3. Please list your primary leisure activities:

_____

_____

_____

4. Are you pregnant? Yes ☐ No ☐

5. Last seen by referring Physician (date) _____ **Next Appointment** (date) _____

6. Have you had any of the following diagnostic tests for this issue? (Check all that apply)
☐ X-Ray ☐ MRI ☐ CT/CAT ☐ EMG/Nerve
☐ Other _____
Results: _____

7. Have you received previous treatment for this issue? ☐ YES ☐ NO
If yes, please explain (ie- surgery, hospitalization, PT, injections, etc):

_____

_____

_____

8. Are you currently being treated by any other physician or therapist?
If yes, please list their name & your condition being treated.

1. _____ Condition: _____
2. _____ Condition: _____
3. _____ Condition: _____
4. _____ Condition: _____

9. Have you recently noted: (Check all that apply)

☐ Unexpected Weight Loss? _____lbs ☐ Unexpected Weight Gain? _____lbs
☐ Nausea / Vomiting ☐ Fatigue
☐ Weakness / Lethargy ☐ Fever /Chills / Night Sweats
☐ Loss of Appetite ☐ Numbness / Tingling
☐ Other_____

10. Do you have/ have you had any of the following problems? (Check all that apply)

YES	NO	SYMPTOMS	YES	NO	SYMPTOMS
☐	☐	**Alcoholism**	☐	☐	**Heart Disease Problems**
☐	☐	**Angina**	☐	☐	**Heart Attack**
☐	☐	**Asthma**	☐	☐	**Heart Palpitations**
☐	☐	**Back Injury**	☐	☐	**High Blood Pressure**
☐	☐	**Breathing Difficulties**	☐	☐	**Kidney Problems**
☐	☐	**Bronchitis**	☐	☐	**Metal Implants**
☐	☐	**Blood Disorder**	☐	☐	**Multiple Sclerosis**
☐	☐	**Bleeding**	☐	☐	**Other Condition of Nervous System**
☐	☐	**Cancer**	☐	☐	**Osteoarthritis**
☐	☐	**Chemical Dependency**	☐	☐	**Osteoporosis**
☐	☐	**Chest Pain**	☐	☐	**Pacemaker**
☐	☐	**Diabetes**	☐	☐	**Respiratory Problems**
☐	☐	**Dizziness**	☐	☐	**Rheumatoid Arthritis**
☐	☐	**Depression**	☐	☐	**Seizures**
☐	☐	**Epilepsy**	☐	☐	**Skin Abnormalities**
☐	☐	**Emphysema**	☐	☐	**Stroke**
☐	☐	**Fracture**	☐	☐	**Smoking**
☐	☐	**Fainting**	☐	☐	**Surgeries** (list below)
☐	☐	**Headaches**	☐	☐	**Other health conditions** (list below)

If yes to any of the above, please explain/ list:

_____

_____

_____

_____

11. Do you have any allergies (including food related)? ☐ YES ☐ NO
If yes, please list:

_____

_____

_____

12. Current medications & conditions for which they are taken:

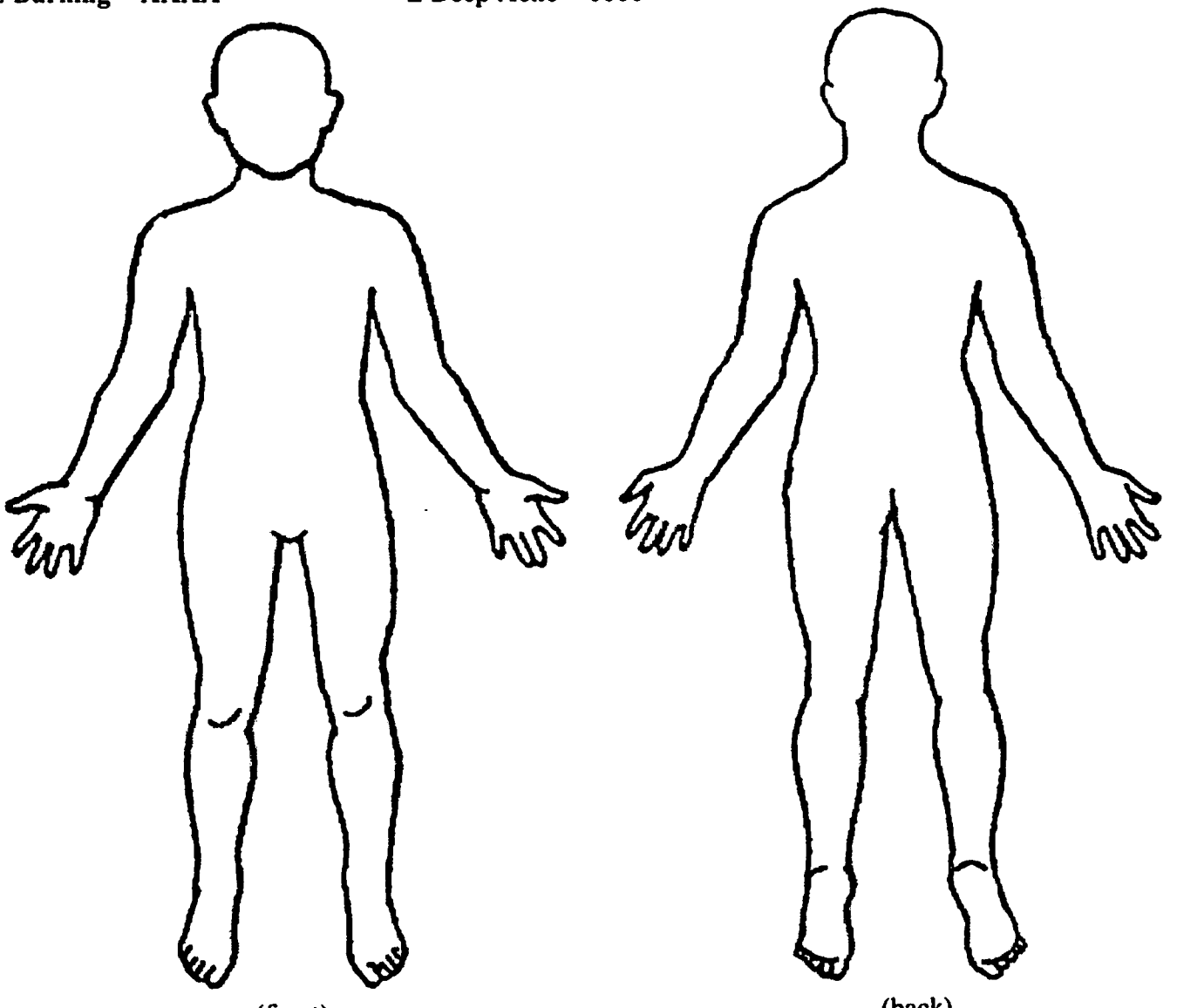
(Please include prescriptions, over the counter medicines, vitamins, mineral/herbal supplements, dietary/ nutritional supplements).

Drug name	Dosage (how much)	Frequency (how often)	Route (oral/ topical/ inhalation etc)

13. Please use the diagram below to indicate where you feel symptoms right now.
Use the following key to indicate your different symptoms:

□ **Pins & Needles = ++++** □ **Stabbing = / / / /**

□ **Burning = XXXX** □ **Deep Ache = 0000**



(front) (back)

The above stated information is true and accurate to the best of my knowledge.

Print Name: _____ **Date:** _____

Patient's Signature: _____

Signature of Parent or Legal Guardian: _____
(if patient is under 18)

Reviewed by: _____ **Date:** _____