

Patient Medical History Profile

Name \_\_\_\_\_

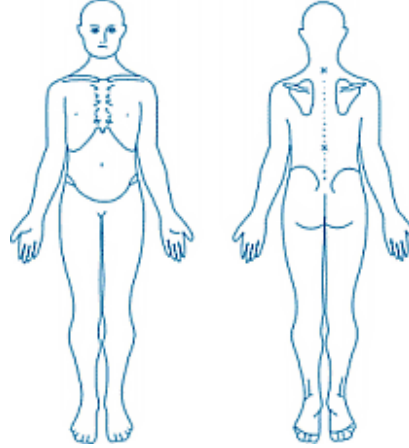
Date: \_\_\_\_\_

Briefly describe your injury/onset \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Mark the location of your symptoms.



Are your symptoms constant or intermittent? \_\_\_\_\_

Pain Level: (0-10) \_\_\_\_\_ 0=No Pain, 5=Moderate Pain, 10=Worst Pain

Since onset of symptoms, have they become: Worse Better Same

Have you had surgery for your condition? Yes \_\_\_\_\_ No \_\_\_\_\_

Is there one movement or position that will produce/increase your symptoms?  
\_\_\_\_\_

What treatments have you had for this current problem? \_\_\_\_\_

Do you have a history of any of the following: \_\_\_\_\_ Cancer If yes, what kind? \_\_\_\_\_

\_\_\_\_ Pacemaker      \_\_\_\_ Anemia      \_\_\_\_ Epilepsy      \_\_\_\_ Head Injuries

\_\_\_\_ Broken Bones      \_\_\_\_ Arthritis      \_\_\_\_ Car accident      \_\_\_\_ Coordination

\_\_\_\_ Heart Disease      \_\_\_\_ Headaches      \_\_\_\_ Generalized Weakness      \_\_\_\_ Difficulty Walking

\_\_\_\_ High blood pressure      \_\_\_\_ Stroke      \_\_\_\_ Muscular Disease      \_\_\_\_ Dizziness

\_\_\_\_ Joint Problems      \_\_\_\_ Diabetes      \_\_\_\_ Neck Injuries

\_\_\_\_ Lung Disease      \_\_\_\_ Back Injuries      \_\_\_\_ M.S./ Neurological Disease

Are you taking any medications presently? No \_\_\_\_\_ Yes \_\_\_\_\_ if so, please list: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

Do you have any pain or discomfort with any of the following activities?

Sleeping\_\_\_\_ Dressing\_\_\_\_ Sitting\_\_\_\_ Standing\_\_\_\_ Walking\_\_\_\_ Housework\_\_\_\_ Driving\_\_\_\_ Stairs\_\_\_\_

Sporting Activities\_\_\_\_ Yard work\_\_\_\_

**What goals do you want to achieve with therapy?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_