

# Re**Quest** Physical Therapy

## PATIENT SUMMARY

*To better serve you, it is important that you complete this medical history as completely and as accurately as possible*

### PART IA PERSONAL INFORMATION

Name (as you like to be addressed) \_\_\_\_\_

Mailing Address \_\_\_\_\_

Age \_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone Number (\_\_\_\_) \_\_\_\_\_ Email \_\_\_\_\_

Date of Initial Injury \_\_\_\_\_ Referring Physician \_\_\_\_\_

Date of Most Recent Increase of Symptoms \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Please check the appropriate response

	YES	NO
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
Do you exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>
Is your current condition work accident related?	<input type="checkbox"/>	<input type="checkbox"/>
Is your current condition auto accident related?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had physical, occupational, speech, massage or chiropractic care for any reason this year?	<input type="checkbox"/>	<input type="checkbox"/>

### PART I PAST MEDICAL HISTORY

Please check YES if you have ever (in your life) had, or do you presently have any of the following

		YES			YES			YES
1	Anemia / Blood Disease	<input type="checkbox"/>	9	Diabetes	<input type="checkbox"/>	17	High Blood Pressure or High Cholesterol	<input type="checkbox"/>
2	Bone / Joint Problem	<input type="checkbox"/>	10	Dizziness / Fainting	<input type="checkbox"/>	18	Lung Disease	<input type="checkbox"/>
3	Arthritis / Rheumatism	<input type="checkbox"/>	11	Epilepsy / Seizure Disorder	<input type="checkbox"/>	19	Paralysis	<input type="checkbox"/>
4	Allergies	<input type="checkbox"/>	12	Fibromyalgia Syndrome	<input type="checkbox"/>	20	Pregnancy (Current)	<input type="checkbox"/>
5	Back Trouble	<input type="checkbox"/>	13	Headaches	<input type="checkbox"/>	21	Skin Disease or Sores That Won't Heal	<input type="checkbox"/>
6	Breathing Problems (any kind)	<input type="checkbox"/>	14	Head / Spinal Injury	<input type="checkbox"/>	22	Stroke	<input type="checkbox"/>
7	Broken Bones / Dislocation / Sprains	<input type="checkbox"/>	15	Heart Disease / Chest Pain	<input type="checkbox"/>	23	Swelling of Feet or Joints	<input type="checkbox"/>
8	Cancer or Tumor	<input type="checkbox"/>	16	Hernia / Rupture	<input type="checkbox"/>	24	Other	<input type="checkbox"/>

Please give details of all above YES answers below (listing the corresponding number)

Number	Illness Details

**Please continue on Back**

**PART II PAST SURGERIES**

If you have had any prior surgeries please give details below

Surgery / Procedure	Date

**PART III MEDICATIONS**

Are you allergic to any medications? YES / NO If YES, what? \_\_\_\_\_

If you are currently taking any medications please list below

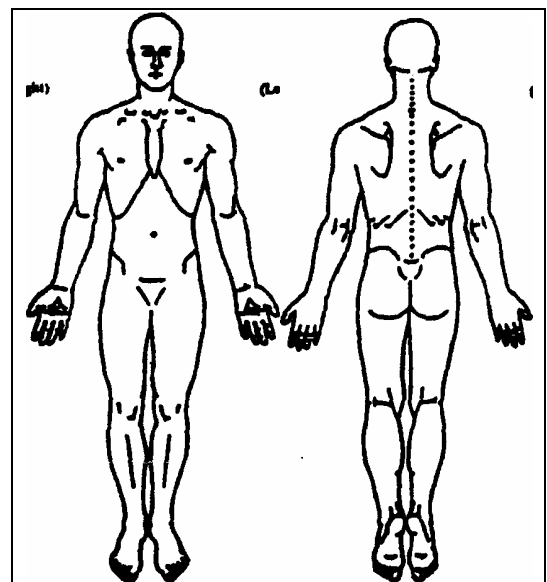
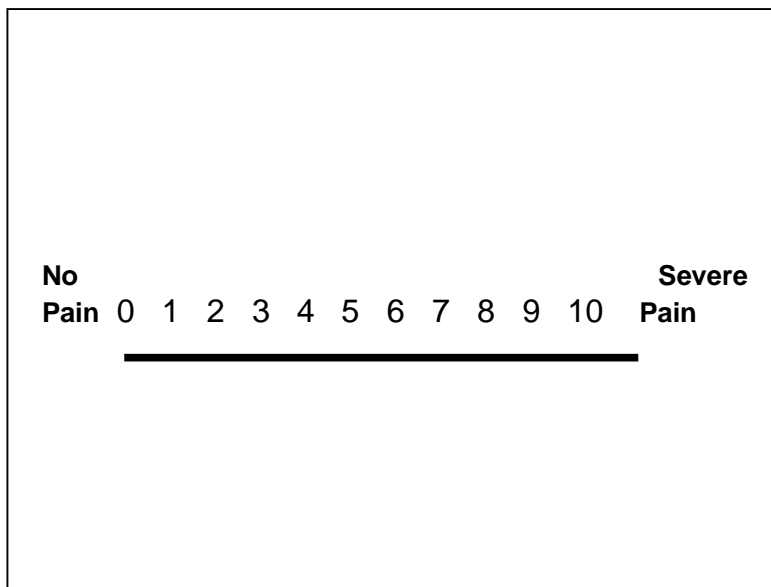
Medication	
1	
2	
3	
4	

Medication	
5	
6	
7	
8	

**PART IV PAIN LEVEL EVALUATION**

Using the 0 to 10 scale below, please circle your pain level during the last week

Using the chart below and to the right, please indicate with an "X" the location of any pain, numbness or tingling you have experienced during the last week



*"I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge"*

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date