PROACTION
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Date: _____

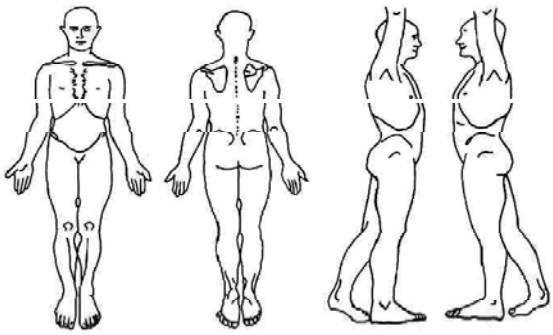
Name: _____ Gender: Male ☐ Female ☐ Age: ____ Date of Birth: _____

Address:_____ Home Phone: _____ Cell Phone_____

_____ Email: _____

Occupation: _____ Are you currently working? Yes ☐ No ☐ Full-time ☐ Part-time ☐ Student ☐

Current Symptoms: Please mark your affected area on the diagram using: XXXX = pain, 0000 = tingling/numbness



Date of Onset/Injury (MM/DD/YYYY): ____/____/____ Briefly describe how and when you current symptoms began: _____

_____

_____

Are you currently being treated by:

Another Therapist:	Yes ☐ No ☐	Or within the last 12 months? Yes ☐ No ☐
Chiropractor/ Osteopath:	Yes ☐ No ☐	Or within the last 12 months? Yes ☐ No ☐
Home Health Agency:	Yes ☐ No ☐	Or within the last 12 months? Yes ☐ No ☐

Date of last MD visit pertaining to current injury: _____ Next scheduled visit with referring MD: _____

Have you had any previous injury or surgery to this related region: Yes ☐ No ☐

If yes, please explain and provide dates: _____

Medical History: Please check if you have ever had (check all that apply):

☐ Dizziness	☐ Numbness	☐ Circulation Problems	☐ Gout	☐ Cancer (location _____)
☐ Diabetes	☐ Pacemaker	☐ Currently Pregnant	☐ Allergies	☐ Tumors (location _____)
☐ Seizures	☐ Arthritis	☐ Heart Disease	☐ Heart Attack	☐ Cardiac Condition (explain _____)
☐ Osteoporosis	☐ Hernia	☐ Shortness of Breath	☐ Stroke	☐ Neurological Disorders (i.e. MS, ALS)
☐ Headaches	☐ Loss of Balance	☐ Infectious Disease		☐ High or Low Blood Pressure
☐ Metal Implants	☐ Difficulty Sleeping	☐ Pain with Cough/Sneeze		☐ Bowel/Bladder Changes
☐ Peripheral Vascular Disease		☐ Asthma		☐ Other (explain _____)

Major surgeries since birth (date/procedure): _____

_____

Patient Name: _____

Has your physician placed you on any work restrictions/precautions? No ☐ Yes ☐, Please Explain: _____

Please list current medications, including dosage: _____

_____

Diagnostic Testing: ☐ X-ray ☐ MRI ☐ CT ☐ NCV ☐ Other Known findings: _____

Allergies to Adhesive: Yes ☐ No ☐ Allergies to Lotions: Yes ☐ No ☐ Other Allergies: Yes ☐ No ☐ (explain _____)

Current symptoms **improve** with (check all that apply):

☐ Cold/Ice ☐ Heat ☐ Massage ☐ Medication ☐ Standing ☐ Sitting
☐ Lying ☐ Squatting ☐ Bending ☐ Walking ☐ Other (explain _____)

Current symptoms are made **worse** with (check all that apply):

☐ Sitting ☐ Sports/Hobbies ☐ Walking ☐ Housework (explain _____)
☐ Yard work ☐ Computer work ☐ Reaching overhead ☐ Driving (explain _____)
☐ Lifting ☐ Other (explain _____)

Pain Description: (Check all those applicable):

☐ Constant ☐ Burning ☐ Sharp ☐ Achy ☐ Tingling ☐ Radiating (location _____)
☐ Dull ☐ Stiff ☐ Tight ☐ Numb ☐ Throbbing ☐ Intermittent

Pain / Symptom Intensity: Rate your pain / symptom intensity by marking an 'X' on the following scales:

At Best: 0 ——— 10
No Pain Worst Pain Imaginable

At Worst: 0 ——— 10
No Pain Worst Pain Imaginable

Goals: What are your goals and expected outcomes for physical therapy? _____

_____

_____ _____
Patient Signature Date

Patients under 18 years of age:

_____ _____
Parent / Guardian Signature Date