ALL IN Sports Orthopedics Spine Physical Therapy

PATIENT MEDICAL HISTORY FORM

Name: _____ Treating Physician: _____ Primary Care Physician: _____
Date of 1st Doctors Visit for this Injury: _____ Last Day Worked Due to this Injury (if applicable): _____
Date Returned to Work after Injury (if applicable): _____ Have you retained an attorney as a result of your injury? YES NO
Referral Source: Surgeon Rehab MD Other: _____
Have you had Surgery for this Injury? YES NO Number of Surgeries: Type of Surgery(ies): _____
Date of Surgery: _____ Date of Injury or Onset: _____ _____

Are you currently taking any medications (prescription and/or over the counter medicines):

Anti-Inflammatories	YES	NO	If YES, please specify: _____
Muscle Relaxers	YES	NO	If YES, please specify: _____
Pain Medication	YES	NO	If YES, please specify: _____
Other	YES	NO	If YES, please specify: _____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode

	YES		YES
Chiropractor	____	Orthopedist	____
General Practitioner	____	Podiatrist	____
Massage Therapy	____	MRI	____
Neurologist	____	CT Scan	____
Occupational Therapy	____	Myelogram	____
Physical Therapy	____	EMG/NCV	____
Emergency Room	____	X-Rays	____

Do you now or have you ever had any of the following?

	YES		YES
Asthma, Bronchitis, or Emphysema	____	High Blood Pressure	____
Anemia	____	Shortness of Breath/Chest Pain	____
Heart Attack or Surgery	____	Diabetes	____
Coronary Heart Disease or Angina	____	Thyroid Trouble/Goiter	____
Gout	____	Cancer/chemotherapy/Radiation	____
Dizziness or Fainting	____	Weakness	____
Emotional/Psychological Problems	____	Infectious Diseases	____
Hernia	____	Bowel or Bladder Problems	____
Numbness or Tingling	____	Allergies	____
Severe or Frequent Headaches	____	Elbow/Hand Injury	____
Osteoporosis	____	Vision or Hearing Difficulties	____
Neck Injury/Surgery	____	Stroke/TIA	____
Sleeping Problems/Difficulties	____	Back Injury/Surgery	____
Blood Clot/Emboli	____	Leg/Ankle/Foot Injury/Surgery	____
Knee Injury/Surgery	____	Epilepsy/Seizures	____
Do you have a Pacemaker?	____	Arthritis/Swollen Joints	____
Varicose Veins	____	Any Pins or Metal Implants?	____
Are You Pregnant?	____	Joint Replacement	____
Weight Loss/Energy Loss	____	Do You Smoke?	____
		Concussion(s)?	____ If yes, how many? ____

Please list any additional information that would assist us in providing care to you? _____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

What are your expectations/goals? _____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature: _____ **Date:** _____

Patient/Legal Guardian Name: _____

Therapist's Signature: _____ **Date:** _____