ultra Physical Therapy & Hand Center

Medical History Form

Patient Name:_____ **DOB:**_____

Date of injury:_____

Diagnosis as stated to you by your physician (if referred by):_____

How did this injury/ exacerbation occur?_____

Have you been hospitalized for the present condition? ❑ Yes ❑ No If Yes, date:_____

Have you had surgery for the present condition? ❑ Yes ❑ No If Yes, date:_____

If yes, surgery type:_____

Have you had any falls this past year? ❑Yes ❑No If Yes, how many?_____

Have you received previous treatment for this condition? ❑ Yes ❑ No If Yes, date:_____

If yes, please summarize:_____

Have you ever had any of the following?

❑ EMG ❑ CT SCAN ❑ MYELOGRAM ❑ MRI ❑ XRAY

Have you ever, or are you presently being treated for any of the following conditions?

Angina	Yes	No
Anxiety or Panic Disorders	Yes	No
Arthritis (RA, OA)	Yes	No
Asthma	Yes	No
Chronic Obstructive Pulmonary Disease	Yes	No
Congestive Heart Failure (CHF)	Yes	No
Degenerative Disc Disease (back disease, spinal stenosis, severe chronic back pain)	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Emphysema	Yes	No
Hearing Impairment	Yes	No
Heart Attack	Yes	No
Multiple Sclerosis	Yes	No
Osteoporosis	Yes	No
Parkinson's Disease	Yes	No
Peripheral Vascular disease	Yes	No

Stroke or TIA	Yes	No
Upper Gastrointestinal Disease (ulcer, hernia, reflux)	Yes	No
Visual Impairment (cataracts, glaucoma, macular degeneration)	Yes	No
Allergies	Yes	No
Bleeding Disorders	Yes	No
Bowel / Bladder Abnormalities	Yes	No
Cancer	Yes	No
Dizzy or Fainting Spells	Yes	No
Epilepsy or Seizure Disorder	Yes	No
Fracture	Yes	No
Hepatitis A, B, C	Yes	No
Hernia	Yes	No
High Blood Pressure	Yes	No
Pacemaker	Yes	No
Pregnancy	Yes	No
Skin Abnormalities	Yes	No

Patient Name:_____ **DOB:**_____

Are you on any medications? Please list (you may use reverse side):_____

_____

To help us understand your symptoms, please circle all that apply.

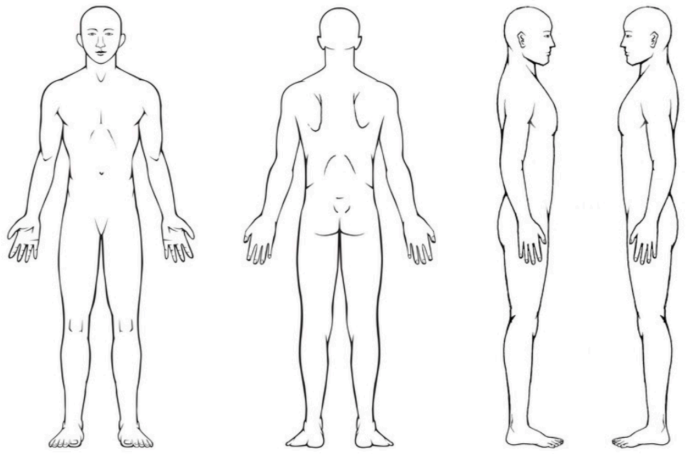
My pain is worse: in the morning / during the day / at night / constant / with activity / during rest

On a scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization)

Please rate your pain at its best_____and at its worst_____

Pain Diagram

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition



Key

↑ or ↓ Radiating Pain
XXX Spasm
ZZZ Tenderness
//// Numbness/Tingling
000 Ache/Pain

Is there any other information regarding your medical history that we should know about?_____

_____

What is your goal for therapy at this time?_____

_____

I will advise the therapist if there are any changes in my physical condition that would alter my response to any of the questions on this form.

Consent to Physical Therapy Intervention: I hereby authorize the healthcare providers of Ultra Physical Therapy & Hand Center to administer physical therapy interventions and procedures, as they deem professionally and clinically necessary. I understand that physical therapy interventions may, but are not limited to: electrical/thermal modalities, therapeutic exercise, hands on manual therapy and manipulation and instrument assisted soft tissue mobilization. I understand that every attempt to explain each intervention will be made by the treating clinician. I acknowledge that I have the right to inquire about the clinical rationale for each intervention performed. I understand that physical therapy is a voluntary healthcare service and I, or the treating clinician, may choose to discontinue any intervention at any time. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the physical therapy intervention.

*Patient Signature:*_____ *Date:*_____