Dresher Physical Therapy

Orthopedic • Post-Operative • Sport • Spine

PAST MEDICAL HISTORY

NAME: ______________________________

DATE: ______________________________

On a scale of 0, being no pain, to 10 being emergency room level pain, please rate your pain level:

Worst: ____________ **Best**: ____________ **Current**: ____________

Is your pain…

Improving ☐ **Worsening** ☐ **Unchanging** ☐

Are you currently working?	☐ YES	☐ NO
Have you ever had these symptoms before?	☐ YES	☐ NO
Have you had a related surgery?	☐ YES	☐ NO
If female, are you pregnant?	☐ YES	☐ NO
Have you had physical therapy or chiropractic care in this calendar year?	☐ YES	☐ NO

If yes, please list the number of visits & location: ____

Current Height: _______________ Current Weight: _______________

Which of the following apply to your current condition?

Work related injury

Recurrence of previous injury

Motor vehicle accident

Inury related to lifting

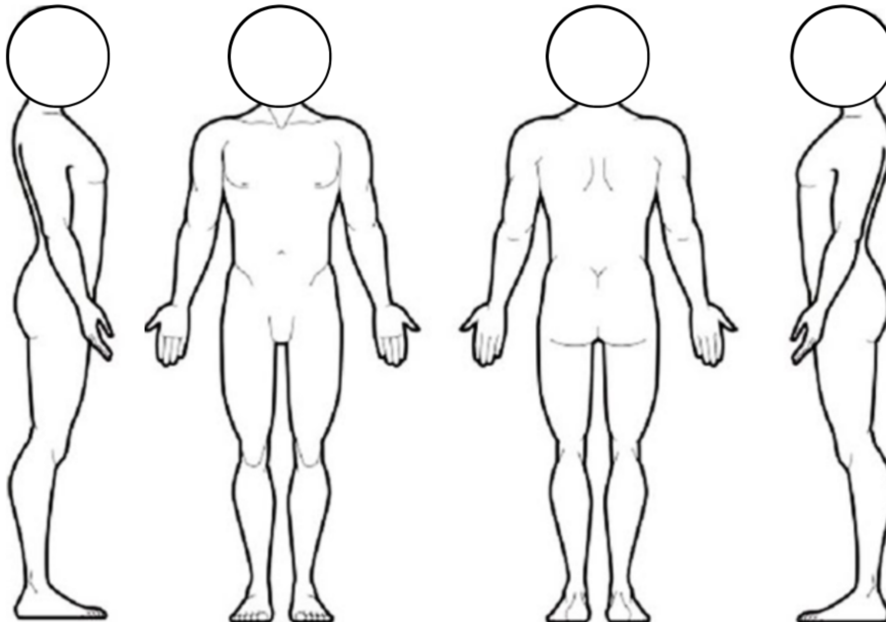
Injury related to falling

Athletic/recreational injury

Cause unknown

Other: ______________________

Please indicate below where your symptoms are located:



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Do you have any allergies? ☐ **Yes** ☐ **No**

If yes, please list your allergies:

____

____

Are you taking any medication? ☐ **Yes** ☐ **No**

If yes, please list your allergies:

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<u>Please circle any of the following conditions that you currently have or previously had:</u>

- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Chest Pain / Angina
- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Heart Palpitations
- ☐ Pacemaker
- ☐ Hypoglycemia
- ☐ Liver / Gallbladder Issues
- ☐ Parkinson's
- ☐ Multiple Sclerosis
- ☐ Headaches
- ☐ Kidney Problems
- ☐ Cancer
- ☐ Stroke
- ☐ Seizures
- ☐ Nausea / Vomiting
- ☐ Dizziness / Fainting
- ☐ Asthma /Difficulty Breathing
- ☐ Ringing In Your Ears
- ☐ Depression
- ☐ Anxiety
- ☐ Osteoarthritis Surgeries
- ☐ Osteoporosis
- ☐ Fracture(s)
- ☐ Rheumatic Arthritis
- ☐ Autoimmune Disorder
- ☐ Metal Implants
- ☐ Hernia
- ☐ Stool / Urine Leakage
- ☐ Constipation
- ☐ Abdominal/Pelvic Pain
- ☐ Urinary Frequency

If you answered **<u>yes</u>** to any of the above, please explain and give the date. Please include any additional information regarding your past medical history**, as well as any pertinent surgical history**

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