PHYSICAL THERAPY
COMPLETE CARE REHAB

MEDICAL HISTORY

Name _____

Age _____ Patient's # _____

Occupation _____ Circle activities at work: SIT - STAND - WALK - LIFT – CARRY Other _____

PAIN SCALE: PLEASE CIRCLE LEVEL OF PAIN 10 BEING HIGHEST 1 2 3 4 5 6 7 8 9 10

Where is the location of the pain? _____

How often does pain occur? _____

What does your pain prevent you from doing? _____

What makes the pain feel better? _____

Medical History: _____

High Blood Pressure	Y N	Pacemaker	Y N
Heart Condition	Y N	Seizure	Y N
Strokes	Y N	Cancer If Yes, Where _____	Y N
Diabetes	Y N	Allergies	Y N
Arthritis	Y N	Other	Y N
Are you pregnant or suspect pregnancy (For Females)	Y N	Autoimmune Disorders	Y N
Any Past Surgeries	Y N	What Kind _____	Y N

Have your been admitted to the hospital in the fast 2 years?
What Condition _____ What Hospital _____
Have you received Physical Therapy in the last year? Y N
What condition _____ Where _____
Treatment Received _____ Was it effective _____
Are you receiving massage or chiropractic treatment now? Y N
Are you receiving any type of home health service (nurse, therapist, home aide) now? Y N
Please Check test received:
( ) X-RAY ( ) EKG ( ) EMG ( ) TREAD MILL STRESS
( ) ULTRASOUND ( ) CAT SCAN ( ) MRI ( ) PET SCAN ( ) Others
List medications: _____

_____

Are you exercising at home? (Activities) _____
List Of Doctor(s) _____

_____

Patient Signature _____ Date: _____
Therapist Signature _____
Comments: _____

_____