PIPELINE PHYSICAL THERAPY

# PATIENT MEDICAL HISTORY FORM

Patient Name:_______________ Gender: ☐ Male ☐ Female Date:__________

Referring Physician:_______________ Return Visit Date:__________

Body Part: _______________ Date of Injury:__________ Surgery Date:__________

Occupation: _______________ Work Status: ☐ FT ☐ PT ☐ Unemployed

Hobbies: _______________ Prior Treatment: _______________

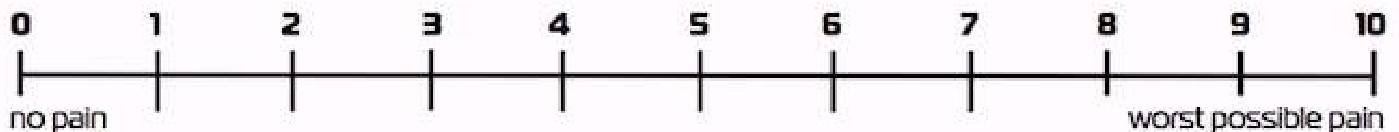
Height: __________ Weight: __________

**What is the nature of the current injury?**

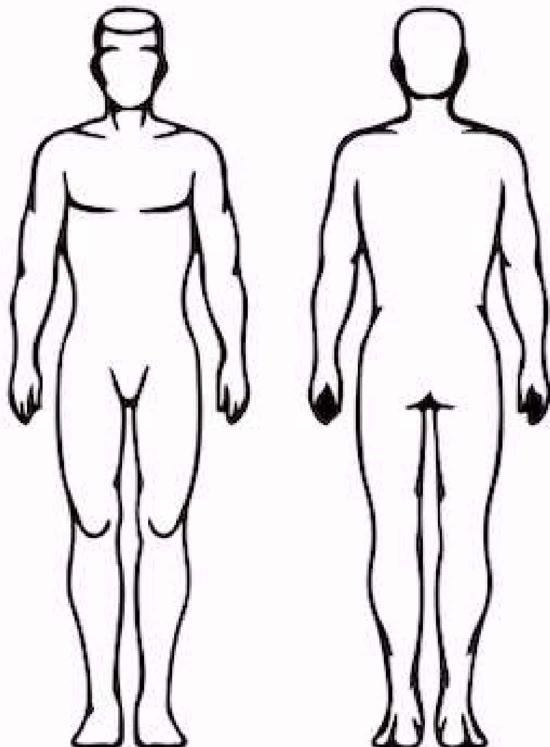
☐ Work Related ☐ Chronic/Reoccurring ☐ Fall ☐ MVA

☐ Recreational ☐ Lift or Carry ☐ Insidious ☐ Surgery

What is your pain rating in the last 24 hours? 0-10 Numeric Pain Rating Scale




**Please use the diagram below to mark where your current symptoms are.**



**Symbols to Use:**

Aching △△△ Burning XXX
Stabbing /// Numbness - - -
Pins & Needles OOO Radiating →→→

My symptoms are made better by: _______________

_______________

My symptoms are made worse by: _______________

_______________

My Symptoms are:
☐ Constant ☐ Intermittent ☐ Chronic ☐ New

Are your work activities of daily living limited?
☐ Yes ☐ Partially ☐ No

*Continued on the other side*

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What is your goal for physical therapy? ______________________________

How often do you exercise more than 20 minutes per day?

☐ 1x a week ☐ 2x a week ☐ 3x a week ☐ 4x a week ☐ 5x a week ☐ 6x a week ☐ Every day

Do you smoke? ☐ Yes ☐ No

List any recent Diagnostics (Xray, MRI, CT Scan, EEG, EMG, Injections, etc): ______________________________

______________________________

Do you have any allergies to latex, cold, heat or medications? ☐ Yes ☐ No If yes: ______________

Are you on any medications? (Please attach a list)

______________ ______________ ______________

______________ ______________ ______________

Are you on any blood thinners? ☐ Yes ☐ No INR: ______________________________

Have you had Home Health Care or stayed at an Inpatient Facility in the last 30 days? ☐ Yes ☐ No

> If so, where? ______________________________

Have you been discharged? ☐ Yes ☐ No When was your discharge date? ______________

Have you fallen in the last year? ☐ Yes ☐ No If yes, how many times? ______________

> Did you sustain an injury when you fell? ☐ Yes ☐ No If yes, describe: ______________

> Under what circumstances did you fall? (location, assistive device, transferring, etc) ______________

______________________________

**Past Medical History**

> Have you recently noted any of the following? (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Fatigue | ☐ Nausea/Vomiting | ☐ Bowel/Bladder Changes | ☐ Shortness of Breath |
| ☐ Constipation | ☐ Fever/Sweats/Chills | ☐ Unexplained Weight Gain/Loss | ☐ Numbness/Tingling |
| ☐ Visual Changes | ☐ Difficulty Swallowing | ☐ Pain That Keeps You Awake | ☐ Heartburn/Indigestion |
| ☐ Incontinence | ☐ Dizziness/Lightheaded | ☐ Rapid Heart Rate/Palpitations | ☐ Unexplained Cough |
| ☐ Fainting | ☐ Muscle Weakness | ☐ Recent Onset of Headaches | ☐ Other(s) |

☐ Prior Surgeries. Please Describe: ______________________________

> Have you ever been diagnosed with the following? (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Bone/Joint Infections | ☐ High/Low Blood Pressure | ☐ Back Pain (Degenerative, Stenosis, Herniation) |
| ☐ Asthma | ☐ Seizures or Epilepsy | ☐ Lung Disease/COPD/ARDS | ☐ GI Disease (Liver, Ulcer, Hernia, Reflex, Gall Bladder) |
| ☐ Pneumonia | ☐ Diabetes Type 1 or 2 | ☐ Bladder/Urinary/Kidney Disease | ☐ Vascular/Circulation Problems/Blood Clots |
| ☐ Cancer (any) | ☐ Chronic Headaches | ☐ Osteoarthritis/Rheumatoid Arthritis | ☐ Depression/Anxiety/Panic Disorders |
| ☐ Stroke/CVA/TIA | ☐ TB/HIV/Hepatitis A/B/C | ☐ Congestive Heart Failure/Attack | ☐ Neurological Disease (MS, Parkinson's) |
| ☐ Thyroid Condition | ☐ Chest Pain or Angina | ☐ Visual or Hearing Impairments | ☐ Other |

The above information is complete, true and correct to the best of my knowledge.

Patient Signature: ______________________________ Date: ______________