MEDICAL HISTORY FORM

This information is strictly confidential. Your answers will help us determine if physical therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Please be as accurate and specific as possible.

I understand that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand that all examinations and treatments are to be paid for as they are received. I hereby authorize the licensed physical therapist at Resilience Physical Therapy, LLC to examine and treat my condition as she deems appropriate through the use of Physical Therapy and I give authority for these procedures to be performed.

Signature of Patient, _____ Date _____
(or Spouse or Guardian)

PLEASE DO NOT WEAR PERFUMES OR OTHER SCENTS TO THIS OFFICE, AS SOME PATIENTS ARE ALLERGIC

Please FILL OUT and BRING THIS FORM WITH YOU to the first appointment.

PATIENT INFORMATION

PATIENT NAME:			TODAY'S DATE:
ADDRESS:		OCCUPATION (OR PREVIOUS IF RETIRED):	
PHONE (HOME):	(CELL):		(WORK):
EMAIL:	GENDER: ☐ M ☐ F ☐ T	DATE OF BIRTH:	AGE:
MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		HEIGHT:	CURRENT WEIGHT: lbs.
MEDICAL DOCTOR:	PHONE:		FAX:
ADDRESS:	EMAIL:		
REFERRED TO OUR OFFICE BY:	PHONE:		FAX:
ADDRESS:	EMAIL:		
EMERGENCY CONTACT:	PHONE:		AGE(S) OF CHILDREN:
NAME OF PERSON RESPONSIBLE FOR PAYMENT OF PROFESSIONAL SERVICES:			
HAVE WRITTEN PRESCRIPTION? Y / N IF NO, PATIENT SHOULD OBTAIN ONE PRIOR TO 1ST VISIT FOR INSURANCE PURPOSES—IF YOUR INSURANCE REQUIRES IT (see insurance worksheet on website)			

CURRENT HEALTH REPORT

PLEASE DESCRIBE THE PRINCIPLE HEALTH PROBLEMS FOR WHICH YOU CAME TO THIS OFFICE. INCLUDE APPROXIMATE DATE OF ONSET. 1. 2. 3.
WHAT ARE YOUR LONG-TERM GOALS IN COMING TO THIS OFFICE?
HOW LONG HAS IT BEEN SINCE YOU REALLY FELT GOOD?
ARE YOUR PRESENT COMPLAINTS DUE TO INJURY? ☐ NO ☐ YES ☐ AUTO ACCIDENT ☐ OTHER
IS YOUR CONDITION GETTING PROGRESSIVELY WORSE? ☐ NO ☐ YES IF YES, PAIN IS: ☐ CONSTANT ☐ COMES AND GOES
IS YOUR CONDITION INTERFERING WITH YOUR: ☐ WORK ☐ SLEEP ☐ DAILY ROUTINE ☐ OTHER (EXPLAIN)
HAVE YOU LOST ANY DAYS OF WORK? ☐ NO ☐ YES IF YES, DATES
WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?
WHAT MAKES IT FEEL BETTER?
HAVE YOU HAD THIS OR A SIMILAR CONDITION BEFORE? ☐ NO ☐ YES IF YES, EXPLAIN:
HAS ANYONE IN YOUR FAMILY HAD A SIMILAR CONDITION BEFORE? ☐ NO ☐ YES IF YES, WHO?
PAST PHYSICAL THERAPY? ☐ NO ☐ YES IF YES, WHEN? EXPLAIN:
HAVE YOU SEEN OTHER PRACTITIONERS FOR THIS CONDITION? ☐ NO ☐ YES
IF YES, DESCRIBE TREATMENT:
DO YOU WEAR: ☐ GLASSES/ CONTACTS ☐ HEEL LIFTS ☐ ORTHOTICS ☐ DENTAL NIGHT GUARD
HAVE YOU BEEN TREATED FOR ANY OTHER HEALTH CONDITION BY A PHYSICIAN IN THE LAST YEAR? ☐ NO ☐ YES
IF YES, EXPLAIN :
ARE YOU CURRENTLY TAKING PRESCRIPTION MEDICATION? ☐ NO ☐ YES IF YES, WHAT?
HAVE YOU EVER BEEN ON FREQUENT OR PROLONGED ANTIBIOTIC THERAPY (SUCH AS ERYTHROMYCIN, PENICILLIN, TETRACYCLINE, ETC.)? ☐ NO ☐ YES IF YES, WHAT?
CURRENT NON-PRESCRIPTION MEDICATIONS (LAXATIVES, ASPIRIN, ANTIHISTAMINES, DECONGESTANTS, STIMULANTS, ETC.):
ARE YOU CURRENTLY TAKING ANY VITAMINS OR SUPPLEMENTS? ☐ NO ☐ YES IF YES, WHAT?
ALLERGIES OR SENSITIVITIES TO DRUGS, FOODS, POLLENS, CHEMICALS, ANIMALS, ETC.?

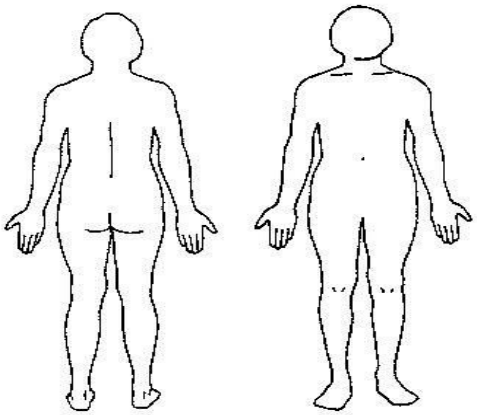
HABITS OF DAILY LIVING

EXERCISE: ☐ None ☐ Moderate ☐ Heavy	☐ <1 PER WEEK ☐ 1-3 TIMES PER WEEK ☐ 4-6 TIMES PER WEEK ☐ DAILY	HOURS PER WEEK
WORK ACTIVITY (CHECK ALL THAT APPLY): ☐ SITTING ☐ STANDING ☐ WALKING ☐LIGHT LABOR ☐ HEAVY LABOR		
STRESS LEVEL: ☐ High ☐ Moderate ☐ Low	DO YOU DO ANY STRESS REDUCTION OR RELAXATION ACTIVITIES? ☐ YES ☐ NO	
ARE YOU CURRENTLY ON PSYCHOTROPIC MEDICATION OR RECEIVING PSYCHOLOGICAL COUNSELING? ☐ YES ☐ NO		
WHAT MEANINGFUL ACTIVITY DO YOU WANT TO DO BUT CAN'T DO NOW?		
SLEEP HABITS: HOURS PER NIGHT:	☐ RESTLESS OR ☐ RESTFUL?	DO YOU SLEEP THROUGH THE NIGHT?
TOBACCO CONSUMPTION: DO YOU SMOKE? ☐ YES ☐ NO	IF YES, HOW MUCH PER DAY?	HOW LONG?
HAVE YOU EVER SMOKED? ☐ YES ☐ NO	HOW MUCH FOR HOW LONG?	
DIET: DO YOU EAT REGULAR MEALS? ☐ YES ☐ NO	DO YOU SIT DOWN FOR MEALS? ☐ YES ☐ NO	
HOW OFTEN DOES YOUR DIET CONSIST MAINLY OF SOME OR ALL OF THE FOLLOWING: SALADS, WHOLE GRAINS, EGGS, FRESH FRUITS AND VEGETABLES, LEAN MEATS, BEANS OR LEGUMES? ☐ RARELY ☐ SOMETIMES ☐ OFTEN ☐ ALMOST ALWAYS		

GENERAL HEALTH HISTORY

LIST ANY MAJOR ACCIDENTS, SERIOUS FALLS OR INJURIES (WITH DATES):
BROKEN BONES, CRANIAL INJURIES:
LIST SURGERIES/ HOSPITALIZATIONS (WITH DATES):
LIST X-RAYS OR SPECIAL IMAGING TAKEN IN THE LAST 10 YEARS AND THEIR DATES:

Please mark where you have pain on this drawing:



Please mark your pain on this scale:

0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10

No pain Worst Pain

SYSTEMS REVIEW

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

	Now	Past		Now	Past
Asthmas, Bronchitis, or Emphysema	_____	_____	Cancer	_____	_____
Shortness of Breath/ Chest Pain	_____	_____	Arthritis	_____	_____
Heart Disease or Angina	_____	_____	Stroke/TIA	_____	_____
Heart Attack or Surgery	_____	_____	Diabetes	_____	_____
High Blood Pressure	_____	_____	Gout	_____	_____
Do You Have a Pacemaker?	_____	_____	Anemia	_____	_____
Blood Clot or Emboli	_____	_____	Allergies	_____	_____
Infectious Diseases	_____	_____	Osteoporosis	_____	_____
Vision or Hearing Problems	_____	_____	Hernia	_____	_____
Thyroid or Goiter Problems	_____	_____	Weakness	_____	_____
Dizziness or Fainting	_____	_____	Weight Loss	_____	_____
Metal in Body or Surgical Implants	_____	_____	Weight Gain	_____	_____
Joint Replacement	_____	_____			
Bowel or Bladder Problems	_____	_____			

Are you aware of your current diagnosis? NO _____ YES _____

Are you currently pregnant? NO _____ YES _____ Estimated Date of Delivery _____

Signature _____ Date _____

Therapist Signature _____ Date _____