Southwest Orthopaedic Physical Therapy

Patient Medical History

Patient Name _____ Date _____

Are you presently working? ☐ Yes ☐ No Date of next physicians visit _____

1. Date of injury/Onset _____
2. Have you ever had these symptoms before ☐ Yes ☐ No
3. Check all that apply to your symptoms:

☐ Work related injury ☐ Reoccurrence of previous injury ☐ Motor vehicle accident

☐ Injury related to lifting ☐ Athletic or recreational injury ☐ Cause unknown

☐ Other_____

Have you had a related surgery? ☐ Yes ☐ No when: _____

Do you currently have or have had in the past any of the following?

☐ Heart Attack ☐ Heart Disease ☐ Heart Palpitations ☐ Chest Pain Angina

☐ High Blood pressure Are you on blood thinners ☐ Yes ☐ No Pacemaker ☐ Yes ☐ No

☐ Diabetes ☐ Type 1 juvenile ☐ Type 2 Adult onset ☐ Do you take insulin?

☐ Asthma/Breathing Difficulties Do you use a rescue inhaler ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Do you smoke? ☐ Yes ☐ No

☐ Headaches ☐ Dizziness/Fainting ☐ Ringing in your ears ☐ Seizures

☐ Kidney problems ☐ Cancer ☐ Hernia ☐ Special diet guidelines

☐ Bowel/Bladder abnormalities ☐ Liver/Gallbladder problems

☐ Allergies to aspirin ☐ Allergies to heat ☐ Allergies/poor tolerance to cold

☐ Recent fractures ☐ Recent Surgery ☐ Metal implants ☐ Rheumatoid arthritis

☐ Skin abnormalities ☐ Sexual dysfunction ☐ Nausea/Vomitting

☐ Other_____

_____

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If you answered yes to any of the previous questions – please explain and give approximate date:

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

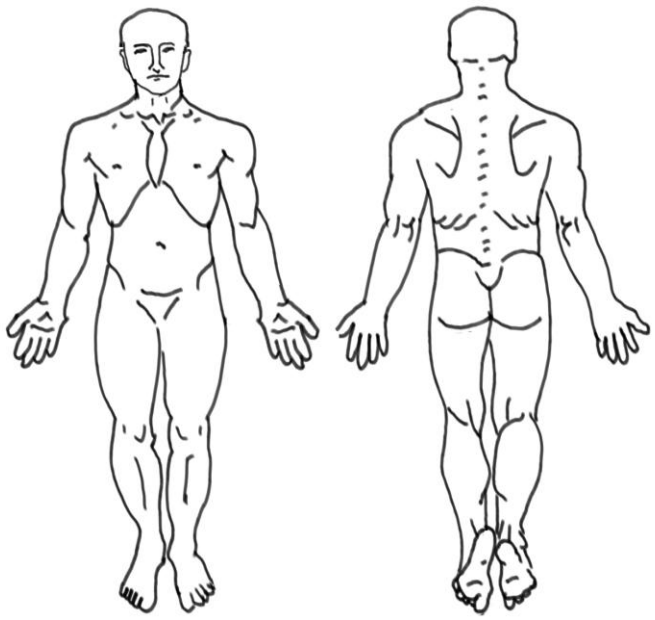
Are you currently taking any medications? ☐ Yes ☐ No If so – please list below

What is the intensity of your pain on a scale of 1 to 10. With 0 being no pain and 10 being the worst

0 1 2 3 4 5 6 7 8 9 10

In the rare instance of an emergency who should we contact?
Name _____Phone _____

Do you participate in any sport, activities, or exercise program on a regular basis ☐ Yes ☐ No



Please show us where your pain is on the illustration above