Patient Medical History Form

Name:_____ Treating Physician:_____

Family Physician: _____ Date of 1st Doctors visit for injury:_____

Is this condition related to an auto accident or work injury? _____**Yes** _____**No** Date: _____

Have you had physical therapy this year? **Y / N** If yes for how long? _____

Have you had physical therapy for this condition? **Y N** If yes for how long?_____

Is an attorney involved in this case? ____**Yes** ____**No** Have you had surgery for this injury? ___Y ____N

Type of surgery: _____

Were you referred to All Star Physical Therapy? _____**Yes** _____**No** If yes by who:_____

Are you currently taking any prescription or non prescription medications? _____Yes _____No (please list below)

Anti-Inflammatories: Yes No _____
Muscle Relaxers: Yes No _____
Pain Medications: Yes No _____
Other: Yes No _____

Have you had any of the following medical or rehabilitative services for this injury/episode?

	Yes	No		Yes	No
Chiropractor	☐	☐	General Practitioner	☐	☐
EMG/NCV	☐	☐	CT Scan	☐	☐
Massage Therapy	☐	☐	MRI	☐	☐
Occupational Therapy	☐	☐	Orthopedist	☐	☐
Physical Therapy	☐	☐	Podiatrist	☐	☐
Emergency Room	☐	☐	X Rays	☐	☐

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

	Yes	No		Yes	No		Yes	No
Asthma, Bronchitis or Emphysema	☐	☐	High Blood pressure	☐	☐	Anemia	☐	☐
Shortness of breath/chest pain	☐	☐	Heart Attack/Surgery	☐	☐	Diabetes	☐	☐
Coronary Heart Disease or Angina	☐	☐	Thyroid Trouble/Goiter	☐	☐	Gout	☐	☐
Cancer/Chemotherapy/Radiation	☐	☐	Dizziness/Fainting	☐	☐	Weakness	☐	☐
Emotional/Psychological Problems	☐	☐	Bowl/Bladder issues	☐	☐	Hernia	☐	☐
Severe Headaches /Migraines	☐	☐	Numbness/Tingling	☐	☐	Allergies	☐	☐
Elbow/Hand Injury	☐	☐	Osteoporosis	☐	☐	Stroke/TIA	☐	☐
Vision/Hearing Difficulties	☐	☐	Neck Injury/Surgery	☐	☐	Blood Clot	☐	☐
Back Injury/Surgery	☐	☐	Knee Injury/Surgery	☐	☐	Pacemaker	☐	☐
Leg/Ankle/Foot Surgery/Injury	☐	☐	Arthritis/Swollen Joints	☐	☐	Pregnant	☐	☐
Any Pins or Metal Implants	☐	☐	Joint Replacement	☐	☐	Varicose Veins	☐	☐
Weight Loss/Energy Loss	☐	☐	Do you smoke?	☐	☐	Epilepsy/Seizures	☐	☐

Please list any other information or illness that would assist us in your care? _____

_____

Are you aware of what your diagnosis is (what your being treated for) _____Yes _____N
Based upon your awareness, what are your expectations/goals while in the program? _____

_____

Patient/Legal Guardian Signature: _____ **Date**:_____