Initial Evaluation Medical History

Please PRINT Clearly:

Patient Name ___________________________
Height____________ Weight_______________
Date of Birth__________________ Age_______
Referring Physician_______________________
Dominant Hand Right _______Left__________

Date _________________Time __________
Employer ____________________________
Job "Function" _______________________
Years at job __________________________
Primary Physician _____________________
Have we seen you before? Yes___ No ___

Reason for Visit____

Date of Injury or symptoms started____________ ***Body Part***_________________________________

Treatments to date: Medications____

PT Y / N Date Started______________ ***Injections***____

Surgery (Date & Surgeon)____

Symptoms Presently____

Pain Level (0-10)______***Constant, Occasional, With Activity*** _________ ***Time of Day*** ____________

Other ____

What makes it worse____

What makes it better ____

Medications AND Doses (inc OTC and Supplements) None ______

Medication Allergies None ______

Latex Allergy Yes / No

Past and Present Medical Conditions None_____

Surgeries None _____

Do you have, or have you ever had:

	Y	N		Y	N		Y	N
Night Sweats / Fever			Glasses / Contacts			Ulcers/ Reflux		
Recent Weight Loss			Visual Problems			Nausea / Vomiting		
Recent Weight Gain			Hearing Problems			Change Bowel / Bladder		
Headache			Kidney Problems			Bladder Infections		
Weakness			Liver Problems			Broken Bones (list)		
Numbness / Tingling			Skin Disease (list)			Any Metal in Body		
Fainting / Dizziness								
Problems Walking			Pacemaker			Anemia		
Balance Problems			Chest Pain			Diabetes		
Stroke / Paralysis			Irregular Heart Beat			Thyroid Problems		
DVT / Blood Clots			Heart Murmur			Cancer		
Fibromyalgia			Shortness of Breath			Trouble Sleeping		
Lupus			Asthma			Depression		
Arthritis OA or RA			Problems w/ anesthesia					
Smoking No. of yrs			Recreational Drugs			Alcohol		
Date Stopped			Pacemaker			Frequency		
Cigarettes per day			Heart Attack					

Family History

	Age	Medical Problems
Father		
Mother		
Brother(s)		
Sister(s)		

Social History (if applicable)

Live Alone Y N Family Member Other

Ambulate Independent Y N Cane Walker Wheelchair Other

Steps Inside Your Home # Steps To Enter Your Home #

Bedroom 1st fl 2nd fl Bathroom 1st fl 2nd fl

Any additional Information that you feel I should be aware of?

By signing I state that all statements made are truthful and accurate.

Patient Signature:____ Reviewer: __________