

North Valley Physical & Occupational Therapy • MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____

CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

HOW DID YOU HEAR ABOUT US? ___ DOCTOR ___ LOCATION ___ FRIEND/FAMILY ___ AD ___ INERNET

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED? YES NO IF YES, WHEN? _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE/WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply):

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> PACEMAKER |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> SUBSTANCE ABUSE |
| <input type="checkbox"/> CARDIAC PROBLEMS | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> METAL IMPLANTS | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> ANY OTHER MEDICAL PROBLEMS: _____ | | | <input type="checkbox"/> CURRENTLY PREGNANT |

SIGNATURE OF PATIENT: _____ REVIEWED BY: _____