RestoreRehab
PHYSICAL THERAPY

664 Tenth Avenue
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www.restorerehabpt.com

Medical History

Name: _____ Age: _____ Date of Birth: _____ Sex: M or F
Name of referring physician _____
When are you scheduled to return to your referring physician? _____
Have you seen anyone else for your current condition?
□ Physician/MD □ Chiropractor □ Podiatrist □ Orthopedic Surgeon
□ Dentist □ Neurologist □ Physical Therapist □ Other (specify: _____)

Presenting Problem:
☐Hip ☐Knee ☐Shoulder ☐Other _____ Side: ☐Right ☐Left ☐ Both; Dominant Hand: ☐Right ☐Left
When did the symptoms start: _____ Was there an injury: ☐Yes ☐No
Injury related to: (check all that apply)
□ Work-related □ Motor Vehicle Accident □ Athletic/Recreational injury □ Recurrence
□ Unknown □ Other (specify: _____)
Have you had similar symptoms before? _____
Have you had previous treatment for this condition? _____
Briefly describe your symptoms:
_____
_____
Rate your pain (circle number): No pain 0 1 2 3 4 5 6 7 8 9 10 Extreme Pain
Do you have pain at night? ☐Yes ☐No
Is your pain worse with exercise or increased activity? ☐Yes ☐No
Are you stiff in the morning? ☐Yes ☐No
How long does it take for the stiffness to go away? ☐15 minutes or less ☐30 minutes or longer
Prior Treatments: ☐Anti-inflammatories ☐Physical Therapy ☐Narcotics ☐Injections ☐Other
Assistive Devices: ☐Cane ☐ Crutches ☐ Walker ☐ Wheelchair

Diagnostic Tests: Please check any tests or procedures that have been done for your current condition
□ X-rays □ MRI □ CT scan □ Bone scan □EMG □Blood work
□ Bone density □ Ultrasound

Past Medical History:
Have you ever had any of the following conditions? Check all that apply.
□High blood pressure □Heart condition □Stroke □Osteoporosis
□Peripheral Neuropathy □Seizures/epilepsy □Vision problems □Diabetes
□Hearing problems □Fainting/dizziness □Emphysema □Frequent or severe headaches
□Bowel/bladder problems □Cancer □Arthritis □Asthma
Have you had any falls in the past year? YES NO If so, about how many? _____
Do you have a history of fractures? YES NO Where? _____
Do you have any metal implants? YES NO Where? _____
□Other: _____
Prior Surgeries (date and surgery):
_____ _____
_____ _____

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Patient's Name_____ **DOB** _____

Current Medications (name, dose, and frequency): Please list any medications (prescribed or over-the-counter) or supplements that you are currently taking:

_____ _____

_____ _____

Allergies:

_____ _____

_____ _____

Are you allergic to latex? ☐Yes ☐No Are you allergic to metals? ☐Yes ☐No

Are you allergic to iodine? ☐Yes ☐No

Social History:

Occupation: _____ Smoke: ☐Never ☐Quit _____ ☐Yes, Packs per day _____

Alcohol: Average drinks per week: _____ (date)

Do you exercise regularly? YES NO How often?_____

Family History:

Medical conditions that run in the family:

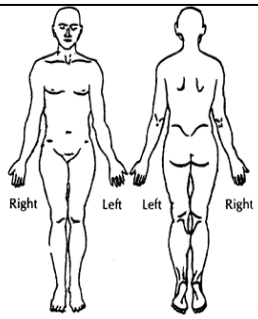
_____

_____

Review of Systems: Please check Yes or No for all symptoms/conditions below

Constitutional symptoms (fever, weight loss, fatigue, etc)	☐No ☐Yes, _____
Eyes (glaucoma, cataracts, etc)	☐No ☐Yes, _____
Cardiac (chest pain, palpitations, faintness, etc)	☐No ☐Yes, _____
Vascular (burning in legs with walking, poor circulation, etc)	☐No ☐Yes, _____
Respiratory (shortness of breath, difficulty breathing, etc)	☐No ☐Yes,_____
Gastrointestinal (abdominal pain, ulcers, bleeding, etc)	☐No ☐Yes, _____
Genitourinary (difficultly or painful voiding, incontinence, etc)	☐No ☐Yes, _____
Musculoskeletal (pain in multiple joints, joint swelling, etc)	☐No ☐Yes, _____
Rheumatologic (rashes, inflammation, pain, etc)	☐No ☐Yes, _____
Neurological (numbness, tingling, difficultly with balance, etc)	☐No ☐Yes, _____
Psychiatric (depression, anxiety, etc)	☐No ☐Yes, _____
Endocrine (diabetes, thyroid, etc)	☐No ☐Yes, _____
Hematologic (excessive bleeding, blood clots, etc)	☐No ☐Yes, _____

BODY CHART
Please fill in body outline to show where your pains are



Height: _____ Weight: _____ Shoe Size_____

For Women:

Are you currently pregnant or think you might be pregnant? ☐No ☐Yes

Office Use Only

Temp: _____ HR: _____ BMI _____

B/P: _____ Respiratory Rate: _____

Physical Therapist: _____ Signature: _____ Date: _____

COMMENTS:

_____