Holmes Physical Therapy, LLC

Medical History Form

Date:_____ /_____/_____

Name: ____________________________________ Age: _____

Your therapist will review this questionnaire to better address your needs. If you do not understand a question, simply leave it unanswered.

What are your symptoms? ____

____

When did your symptoms start?
Please indicate a specific date if possible.____

What caused your symptoms? ____

____

Was the onset of this episode ☐ Gradual or ☐ Sudden? (Check one)

Since the onset are your symptoms getting: (Check one)
☐ Better ☐ Worse ☐ Not Changing

Have you had similar symptoms in the past? (Check one) ☐ Yes ☐ No
More than one episode? (Check one) ☐ Yes ☐ No

Nature of pain/symptoms (Check all that apply)
☐ Sharp ☐ Dull ☐ Aching ☐ Occasional ☐ Burning ☐ Radiating ☐ Stabbing ☐ Constant
☐ Other ____

Are your symptoms worse in the: (Check one)
☐ Morning ☐ Afternoon ☐ Evening ☐ Does not matter

What activities increase your symptoms? (i.e. sitting, walking, driving) ________________________

What relieves/improves your symptoms? ____

Do your symptoms interrupt your sleep? (Check one) ☐ Yes ☐ No

How would you rate your pain today on a scale of 0-10 (10 being most painful) ____________________
How would you rate your **least** pain in the last 7 days? ________________________________
How would you rate your **worst** pain in the last 7 days? ________________________________
Have you been treated by anyone else for this last injury/these symptoms? (i.e. chiropractor, massage therapist, another physical therapist etc.) ____

Have you had any of the following tests related to this condition? (Check all that apply)

☐ Xrays ☐ Bone Density ☐ EMG/NCS ☐ Doppler Study
☐ CT Scan ☐ Bone Scan ☐ Blood Tests ☐ Pulmonary Function Test
☐ MRI ☐ Stress Test ☐ EKG ☐ Other: ________________________

What are your goals for therapy? ____

____

How would you rate your general health? (Check one)

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you exercise outside of normal activities? (Check one)

☐ 5+ days/wk ☐ 1-2 days/wk ☐ 0 days/wk
☐ 3-4 days/wk ☐ Occasionally

Exercise, sports/recreation consisting of: ____

____

***If you want to function at 100% what is your current level of function? (0-100%) ____________**

Do you have a Pacemaker/Defibrillator? (Check one) ☐ Yes ☐ No

Do you have metal implants? (Check one) ☐ Yes ☐ No

Are you pregnant or think you might be pregnant? (Check one) ☐ Yes ☐ No

Do you have any allergies? (Check one) ☐ Yes ☐ No
If YES, please list any allergies that you have (For example: medicines, latex, bee stings, adhesive) ____________________

____

Have you experienced any falls in the past 12 months? (Check one) ☐ Yes ☐ No
If YES, approximately how many times? ______________ Were you injured? ______________________

Have you recently experienced:

	YES	**NO**	**For Therapist's Use Only**
Fever/Chills/Sweats			
Repeated Infections			
Recent Weight Gain/Loss			
Nausea/Vomiting			
Numbness/Tingling (where)			
Weakness in Arms/Legs			
Chest Pain/ Heart Palpitations			
Shortness of breath/Cough			
Dizziness or Loss of Consciousness			
Bowel/Bladder Problems			
Chicken Pox/Shingles			
Heart Problems (explain)			
High Cholesterol			

Have you ever been diagnosed with any of the following conditions:

	YES	NO	For Therapist's Use Only
High Blood Pressure			
Lung Problems/ Tuberculosis			
Infectious Diseases (For example: HIV, MRSA)			
Cancer (type) (date)			
Kidney/ Liver Problems			
Vascular Problems			
Thyroid Problem			
Diabetes			
Stroke (date)			
Blood Disorder (specify)			
Head Injury (date)			
Seizure Disorders or Epilepsy			
Neurological Problem (i.e. PD, MS, MD, Neuropathy, Myelopathy)			
Arthritis (Rheumatoid or Osteoarthritis)			
Osteoporosis or Osteopenia			
Visual/ Hearing Problems			
Gastrointestinal Problems (specify)			
Urological Problems			
Gynecological Problems			
Do you smoke?			
Orthopedic Injury (i.e. fracture, dislocations etc.)			
Tick Born Illness (date)			

Previous Functional Level	Work History	
☐ **Independent in all activities** (work, community, home, recreation)	**Occupation:**____________________	
Self Care	☐ Employed full time	☐ Student
☐ Independent in all self-care activities (bathing, toileting, dressing, etc.)	☐ Employed part time	☐ Homemaker
☐ Difficulty performing self-care activities	☐ Self employed	☐ Retired
☐ Need assistance with self-care activities	☐ Unemployed	☐ Other
☐ Difficulty performing household chores	**Physical activities at work** (check all that apply)	
Social	☐ Sitting	☐ Computer use
☐ Need assistance with activities in community outside of home	☐ Standing	☐ Heavy equipment operation
	☐ Phone use	☐ Driving
	☐ Repetitive lifting	☐ Other____________
Hobbies: ________________________________	☐ Heavy lifting	

Are you currently receiving or seeking disability for this condition? (Check one) ☐ YES ☐ NO

If not performing your normal activities at work do you plan to RETURN to your previous activity level? (Check one) ☐ YES ☐ NO

Have you had any cortisone injections or epidural steroid injections for this problem? Explain ______________________

____

Please list any ***major*** surgeries or other conditions for which you have been hospitalized including approximate date of surgery/ hospitalization (Use back of form is needed)

Do you take any medications? (Check one) ☐ Yes ☐ No

Please list any prescription or non-prescription drugs (i.e. herbal supplements, vitamins) you are presently taking:

Medication	Dosage/Frequency	Route of Administration	Reason for taking

We can make a copy of your medication list if you prefer

Height:__________ **Weight:**__________

Signature: ____Date:______________________________