

Andersonville Physical Therapy Initial Medical History Form

Name _____ Age _____ Date of Birth _____ / _____ / _____
Handedness: Right/Left _____ Today's Date _____ / _____ / _____

What problem/issue brings you here today? _____
How and when did it start? _____
What makes it worse? _____ Better? _____
What do you want to accomplish from today's visit? _____
Is this a Worker's Compensation Claim? Yes/No _____
Is there litigation pending? Yes/No _____
What diagnostic test have you had for this problem? X-Ray / MRI / CT scan / EMG / Bone scan _____
What treatments have you had? Massage/Injections/Physical Therapy/Psychotherapy/Chiropractic _____

Rate your pain 0-10 (0=no pain, 10=worst pain) _____
Please describe your pain: *circle all that apply*
Dull/Achy/Burning/Stabbing/Numbness/Tingling/Pulling/Cramping/Tightness _____
Please describe the time course of your pain:
Constant/Comes and goes/Getting worse/Getting better/Staying about the same _____

Medications (Current):
*All medications including
Prescription, over-the-counter
(i.e. Advil), supplements, vitamins* _____

Medical/Surgical History:
*All surgeries, diabetes, cancer,
High blood pressure, heart attack
Pacemaker, arthritis, fractures
Accidents, osteoporosis* _____

Family History:
*Cancer, heart disease, stroke,
Arthritis, osteoporosis* _____

Occupation: _____ Physical Requirements: *circle all that apply*
Prolonged Sitting/Prolonged Standing/Lifting/Travel/Driving/Computer/Phone/Childcare

Sleep Position: Back / Stomach / Side

For the following please circle Yes or No. If Yes, please specify:

- Night pain, fevers, unintentional weight change? Yes/No
- Vision change, double vision? Yes/No
- Difficulty swallowing, headaches? Yes/No
- Chest pain, palpitations? Yes/No
- Shortness of breath, wheezing, cough after exercise? Yes/No
- Nausea, vomiting, black stools, loss of control of stools? Yes/No
- Loss of control of urine, urinary frequency or urgency? Yes/No
- New rashes or psoriasis? Yes/No
- Dizziness, weakness, numbness, tingling? Yes/No
- Depressed mood, sleep problems, anxiety? Yes/No
- Current low back pain, other joint swelling or muscle pain? Yes/No
- Pain worse with coughing, sneezing, strain? Yes/No
- Women only:* Are you pregnant, trying to get pregnant, or breastfeeding? Yes/No