GOIN BEYOND
PHYSICAL THERAPY

MEDICAL HISTORY

**Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU*

Full Name ____ **Date of Birth** ___ /___ /_____

EMAIL ADDRESS: ____

To receive our monthly newsletter and special updates. Please check here. You can unsubscribe at any time. ❑

Primary Care Physician ________________________ **Referring Physician** ______________________________

Who did you hear about us? ____

What is your major complaint? ____

____

Is this condition: ❑Job related ❑Auto Accident ❑Home injury ❑Other:______________ Date of accident ___/___/_____

Date of Onset/Condition? ____________ **What caused this condition?** ____________________________________

Does anything make this condition feel worse? ____

Does anything make this condition feel better? ____

Is this condition interfering with your: ❑Work/School ❑Sleep ❑Daily Routine ❑Other:________________________

Is this condition: ❑Improved ❑Unchanged ❑Getting Worse

Other Doctors or Therapist who have treated <u>THIS</u> Condition (Please Provide Names)**:**_____________________________

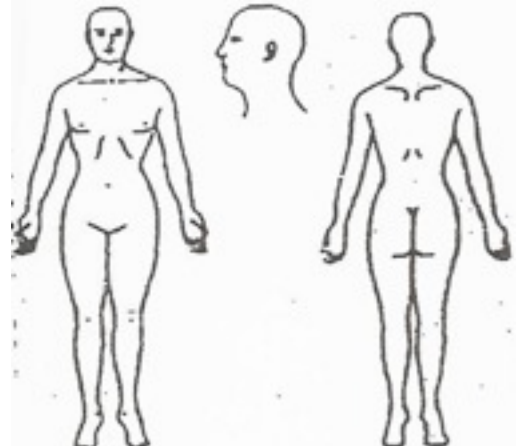
List surgical operations and years: ____

Medications, dosage and frequency: ____

____

Have you had this or similar conditions in the past? ❑Yes ❑No If Yes, Why?______________________________

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES BELOW



<u>Social History:</u>

Current Weight______________ **Current Height** _________

PLEASE CIRCLE: 1 being no pain 10 being severe pain.

Pain level at worst: 1 2 3 4 5 6 7 8 9 10

Pain level currently: 1 2 3 4 5 6 7 8 9 10

Pain level at best: 1 2 3 4 5 6 7 8 9 10

GOIN BEYOND
PHYSICAL THERAPY

MEDICAL HISTORY (Continued)

Full Name ____

MEDICAL HISTORY

Condition	Response	Condition	Response
High Blood Pressure	❑Yes ❑ No	Kidney Problems	❑Yes ❑ No
No Cardiac Condition	❑Yes ❑ No	Liver Problems	❑Yes ❑ No
Heart Attack	❑Yes ❑ No	Cancer	❑Yes ❑ No
Circulation Problems Pacemaker	❑Yes ❑ No	Nervous Disorders	❑Yes ❑ No
Seizures	❑Yes ❑ No	Vision Problems	❑Yes ❑ No
Dizzy Spells	❑Yes ❑ No	Sensitivity to Heat/Cold	❑Yes ❑ No
Diabetes	❑Yes ❑ No	Metal Implants	❑Yes ❑ No
Allergies	❑Yes ❑ No	Are you Pregnant?	❑Yes ❑ No
Fractures	❑Yes ❑ No	Arthritis	❑Yes ❑ No
Stroke	❑Yes ❑ No	Lung Issues	❑Yes ❑ No
Autoimmune Disorder	❑Yes ❑No	Blood Clots	❑Yes ❑No
Multiple Sclerosis	❑Yes ❑No	Depression	❑Yes ❑No

Additional details regarding your conditions:

____

____

____

____

*Signature of Patient/Parent or Legal Guardian*______________________________ *Date* ______________