

Momentum Physical Therapy

PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? Yes No

Date of next physician's visit: ____ / ____ / ____

Date of injury / onset: ____ / ____ / ____

Have you ever had these symptoms before? Yes No

Check which apply to your symptoms:

- | | | |
|---|---|--|
| <input type="checkbox"/> Work related injury | <input type="checkbox"/> Recurrence of previous injury | <input type="checkbox"/> Injury related to falling |
| <input type="checkbox"/> Motor vehicle accident | <input type="checkbox"/> Injury related to lifting | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Cause unknown | <input type="checkbox"/> Athletic / recreational injury | |

Have you had a related surgery? Yes No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

If yes on any of the above, please briefly explain and give approximated date:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? Yes No

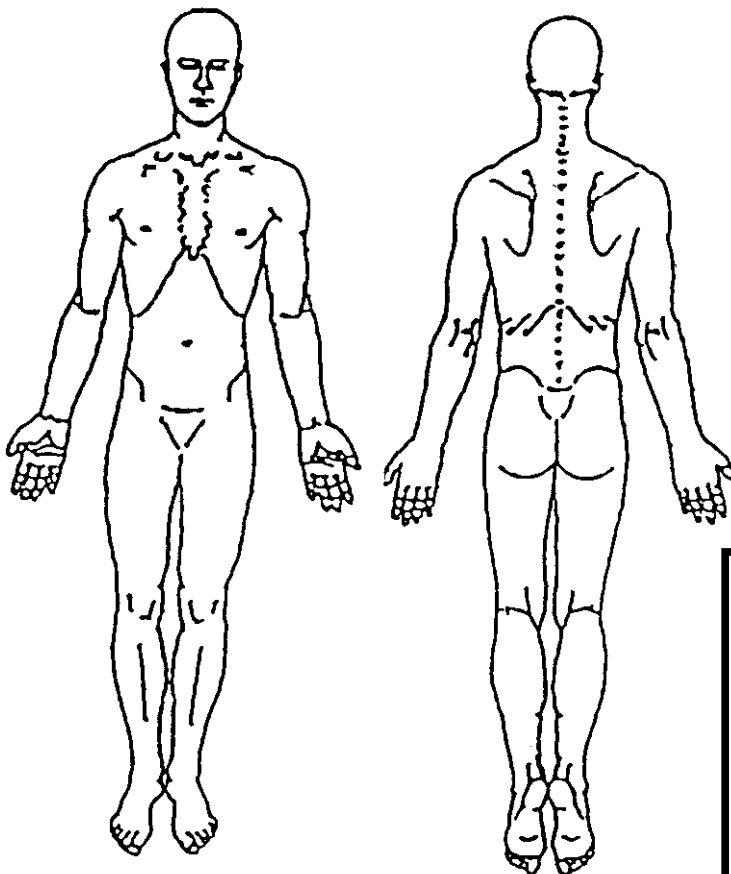
If yes, please list what medications and for what condition:

In the rare instance of an emergency, whom should we contact?

Name: _____

Phone Number: _____

Please indicate below where your symptoms are located.



KEY:

Numbness =====

Pins & Needles ooooooo

Burning Pain xxxxxxxx

Stabbing Pain //////////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: _____.

Patient's Signature

Date

Signature of Guardian if patient is a minor

Date

Therapist Signature

Date / /