PHYSICAL THERAPY & HAND CENTERS

MEDICAL HISTORY FORM

Name: ______________________ Date of Birth: ______________

Age: __________ Referred by: ______________________

DATE OF INJURY: __________ DATE OF SURGERY: ______________

Briefly describe the history of your present condition / problem to be treated:

On a scale of 0 to 10, how much pain/discomfort are you in? (fill bubble)

low — high

0 1 2 3 4 5 6 7 8 9 10

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

Have you ever had physical therapy before? ☐ Yes ☐ No

Have you received treatment for this problem before? ☐ Yes ☐ No If yes, please explain below:

____

Have you had surgery for this condition? ☐ Yes ☐ No

Are you presently taking any medication? ☐ Yes ☐ No If yes, please list below:

____

Do you have or have ever had any of the following:

Condition	Yes	No
Diabetes	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Heart Disease	☐ Yes	☐ No
Headaches	☐ Yes	☐ No
Kidney Problems	☐ Yes	☐ No
Nervous Disorders	☐ Yes	☐ No
Circulation Problems	☐ Yes	☐ No
Back or Neck Pain	☐ Yes	☐ No
Stress	☐ Yes	☐ No
Sensitive to Heat/Ice	☐ Yes	☐ No
Allergies	☐ Yes	☐ No
Hernia	☐ Yes	☐ No
Broken Bones	☐ Yes	☐ No
Sprained Joints	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Dizzy Spells	☐ Yes	☐ No
Muscle Aches/Pain	☐ Yes	☐ No

Question	Yes	No
Do you have a pacemaker?	☐ Yes	☐ No
Do you have any metal implants?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Do you have trouble with vision?	☐ Yes	☐ No
Do you have trouble with hearing?	☐ Yes	☐ No
Do you have trouble with balance?	☐ Yes	☐ No
Have you ever been diagnosed with cancer?	☐ Yes	☐ No
Have you ever had a heart attack?	☐ Yes	☐ No

Please explain any Yes answers below:

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Please list any other major illness, or surgery that has occurred in the past year:

The above information is accurate and complete to the best of my knowledge.

Signature______________________________ Date ______________