Print Form

TEAM PHYSICAL THERAPY

Patient Name: Date:

In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PRESENT ILLNESS OR INJURY:

For what condition or symptoms are we seeing you?

When did this problem begin? (Give date and explain.)

What treatment have you already received?

Where have you received physical therapy treatment for this injury?

Has this problem occurred in the past? If yes, when?

PAST MEDICAL HISTORY (Please indicate if you have had any of the following conditions):

Heart Disease
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Heart Attack (Myocardial Infarction)
- ☐ Atherosclerotic Disease
- ☐ Angioplasty
- ☐ Valvular Disease
- ☐ Stents
- ☐ Arrhythmia
- ☐ Coronary Artery Bypass Graft
- ☐ Angina
- ☐ Pacemaker

Lung Disease
- ☐ Chronic Obstructive Pulmonary Disease
- ☐ Emphysema
- ☐ Asthma
- ☐ Recent Pneumonia

Vascular Disease
- ☐ Peripheral Arterial Disease
- ☐ Acquired Respiratory Distress Syndrome
- ☐ Diabetes
- ☐ Taking Blood Pressure Meds
- ☐ Stroke/TIA
- ☐ Chronic Bronchitis
- ☐ Hypertension

General Medical Conditions
- ☐ Arthritis (rheumatoid/osteoarthritis)
- ☐ Allergies
- ☐ Alcoholism/Drug Abuse
- ☐ Blood Disorders
- ☐ Congenital Abnormalities
- ☐ Neurological Disease (such as MS or Parkinson's)
- ☐ Epilepsy or Convulsions
- ☐ Genital/Gynecological Disorder
- ☐ Headaches
- ☐ Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)
- ☐ Visual Impairment (such as cataracts, glaucoma, macular degeneration)
- ☐ Back Pain (neck pain, low back pain, degenerative disc disease, spinal stenosis)
- ☐ Hepatitis/AIDS/Venereal Disease
- ☐ Prior Surgery(ies)
- ☐ Osteoporosis
- ☐ Anxiety or Panic Disorders
- ☐ Depression
- ☐ Previous Accidents
- ☐ Kidney, Bladder, Prostate or Urination Problems
- ☐ Incontinence
- ☐ Thyroid Disease
- ☐ Hearing Impairment, very hard of hearing even with hearing aids
- ☐ Sleep Dysfunction
- ☐ Prosthesis/Implants
- ☐ Cancer
- ☐ Are you pregnant?

Other medical problems not listed (explain):

SURGERY (list all previous surgeries and give dates):

OTHER SERIOUS INJURIES (list any other serious injuries and approximate dates):

MEDICATIONS (list all present medications):

FAMILY HISTORY (Please indicate if any immediate blood relative had any of the following):

	Yes	No		Yes	No
Cancer	☐	☐	Bleeding tendency	☐	☐
Heart Disease	☐	☐	Diabetes	☐	☐
Arthritis	☐	☐	Stroke	☐	☐

_____
Patient signature

Date