MEDICAL INFORMATION SHEET

Name _____ Date _____
Occupation _____ Height _____ Weight _____ Age _____
How and when did your problem begin _____
What other Healthcare provider have you seen for this problem? _____Any previous PT? _____

Circle the "***greatest***" pain and "***average***" pain you experienced over last 48 hours. (Circle **TWO** numbers)
0 1 2 3 4 5 6 7 8 9 10
No Pain *Worst Possible*

Do you now smoke or have you EVER smoked? YES packs/day ___ years _____ NO
List any allergies_____ Do you regularly exercise? YES NO
With whom do you live? _____ or ___ Alone
Describe your general health __ Excellent ___Good ___Fair ___Poor
Are you now or think you might be pregnant, or attempting to become pregnant? YES NO
Have you declared an Advanced Clinical Directive of Do Not Resuscitate? (Circle) YES NO

PRESCRIPTION MEDICATIONS COMPLETE THE ATTACHED FORM SHOWING ALL RX, OVER THE COUNTER, VITAMINS OR PROVIDE LIST THIS IS A ***MEDICARE*** REQUIRMENT.

CLINICAL TESTS (Over the last 2 years) body part_____

___ MRI	___ XRAY	___ CT Scan	___ Bone Density Scan
___ Bone Scan	___ Angiogram	___ Biopsy	___ EEG (head)
___ EKG	___ EMG	___ Echocardiogram	___ Stress Test
___ Doppler / Ultrasound		Other _____	

Do you have a cardiologist? YES/NO If yes, who? _____

SURGICAL HISTORY TYPE AND YEAR _____
_____

MEDICAL HISTORY check if you EVER had

___ Anemia	___ Headaches	___ Metal Implants/Where?
___ Angina	___ Heart attack	___ Osteoarthritis
___ Asthma	___ Heart disease	___ Osteoporosis
___ Cancer	___ Heart arrhythmias	___ Pacemaker/Defibrillator
Type: _____	___ High Blood Pressure	___ Rheumatoid Arthritis
___ Chest Pain	___ Infectious Disease	___ Seizures/Epilepsy
___ Depression	(eg.TB, HIV, hepatitis)	___ Shortness Breath
___ Diabetes	___ Intestinal problems	___ Skin Diseases
___ Dizziness/Vertigo	___ Joint Replacement	___ Stroke/TIA
___ DVT	___ Neuropathy	__ Other (please list).
___ Fainting	___ Low Back/Neck pain	_____
___ Fractures	___ Low Blood Pressure	_____

How many falls have you had in the last 12 months? _____ ***Did the fall cause any injury?*** _____

In the LAST 6 MONTHS have you experienced (circle) weight loss, nausea/vomiting, dizziness, unexplained weakness, night pain, fall/loss of balance, numbness/ fever/chills/bowel/bladder changes.

SIGN _____ DATE:_____////_____