Returning Patient Information & Medical History Form

Name: _____ Today's Date _____

Emergency Contact: _____ Relationship: _____ Phone Number: _____

What is your regular job? _____

What are your job duties (or activities you perform, if retired)?

1.

2.

How can we help you? _____

If this was a result of an injury, what happened? (If there was no injury, write "no injury")

_____

Date symptoms started? _____

Have you had any surgery that is relevant to the problem that brings you here today? If yes, what was done and when?

_____

Have you had an MRI or x-rays that are relevant to your current condition? ☐ Yes ☐ No

If yes, when & where was testing done?

_____

What is your pain level? 0 = absolutely no pain, 10 = severe pain

At worst:	0	1	2	3	4	5	6	7	8	9	10
Currently:	0	1	2	3	4	5	6	7	8	9	10
At best:	0	1	2	3	4	5	6	7	8	9	10

What makes your pain worse?

What makes your pain better?

What is difficult for you to do?

Have you had Home Health care for the current condition we are seeing you for? ☐ Yes ☐ No

PERFORMANCE
Physical Therapy & Wellness

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Do you have a history of falling? ☐ Yes ☐ No

- **If yes:** Do you take medication that contributes to your falls? ☐ Yes ☐ No
- Do you have a history of your blood pressure dropping when moving from lying down to sitting up? ☐ Yes ☐ No
- Do you have visual problems that may contribute to your falls? ☐ Yes ☐ No

Have you had any unexplained weight loss recently? ☐ Yes ☐ No

How would you rate your general health?

☐ Good ☐ Fair ☐ Poor

Please list all current medications with dosage:

Prescription _____

Over-the-counter_____

Herbals/Vitamins/Mineral Supplements_____

Please list all previous surgeries:

Self-Medical History (Check all that apply)

☐ No known
☐ Cardiovascular Disease
☐ Cauda Equina Syndrome
☐ Cerebral Vascular Accident
☐ Current Infection
☐ Diabetes Mellitus Type 1
☐ Diabetes Mellitus Type 2
☐ Fibromyalgia
☐ Current Fracture/ Suspected Fracture, if yes: _____
☐ High Blood Pressure
☐ History of Cancer
☐ Huntington's
☐ Immunosuppression
☐ Lupus
☐ Muscular Dystrophy
☐ Obesity
☐ Osteoarthritis
☐ Osteoporosis
☐ Parkinson's
☐ Rheumatoid Arthritis
☐ Traumatic Brain Injury

What are your goals for therapy? _____

By signing below, I acknowledge that the information provided above is correct.

Patient (Guardian) Signature: _____ Social Security #_____

Date: _____