CITY PHYSICAL THERAPY, PC

Medical History Form

Name: _____ Referring Doctor: _____

CURRENT INJURY/CONDITION

Please briefly describe your current injury/condition: _____

Please check any of the following healthcare providers that you have seen related to this injury/condition:

☐ Primary Care Doctor ☐ Orthopedist ☐ Physiatrist (PMR) ☐ Osteopath
☐ Massage Therapist ☐ Chiropractor ☐ Acupuncturist ☐ Other: _____

Have you received previous Physical Therapy for this condition? ☐ Yes ☐ No
Have you received surgery for you current injury/condition? ☐ Yes ☐ No
If yes, please indicate the date/type of surgery: _____
Was this injury/condition the result of a work related incident or motor vehicle accident? ☐ Yes ☐ No

GENERAL MEDICAL HISTORY

Please check any conditions you currently have, or have been diagnosed with in the past.

☐ Do you have a pacemaker ☐ Yes ☐ No
☐ Heart Disease/Surgery Please specify: _____
☐ High Blood Pressure If yes, is it controlled by medication? ☐ Yes ☐ No
☐ Stroke/TIA If yes, please specify date: _____
☐ Diabetes If yes, is it controlled by: ☐ Diet ☐ Exercise ☐ Medication ☐ Uncontrolled
☐ Cancer If yes, please specify type and date diagnosed: _____
☐ Infectious Disease If yes, please specify: _____
☐ Allergies If yes, please specify: _____
☐ Joint Replacement If yes, please specify type and date: _____

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Osteoporosis/Osteopenia ☐ Hernia
☐ Kidney Problems ☐ Liver Problems ☐ Thyroid Problems ☐ High Cholesterol
☐ Asthma ☐ Vision Difficulties ☐ Hearing Difficulties ☐ Depression
☐ Chemical Dependency (i.e. alcoholism) ☐ Epilepsy/Seizure Disorder
☐ Other Surgeries: _____
☐ Other Medical Conditions: _____

Are you pregnant? ☐ Yes ☐ No ☐ N/A Are you trying to become pregnant? ☐ Yes ☐ No ☐ N/A
Do you smoke? ☐ Yes ☐ No If yes, how many packs/day? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks/week? _____

MEDICATIONS

Please list any medications/vitamins/herbs/supplements you take regularly, and the dosage.

Type: _____ Dose: _____ Type: _____ Dose: _____
Type: _____ Dose: _____ Type: _____ Dose: _____
Type: _____ Dose: _____ Type: _____ Dose: _____

RECREATIONAL ACTIVITIES

Please indicate the type and frequency of recreational activities that you participate in.

Type: _____ Frequency: _____ Type: _____ Frequency: _____
Type: _____ Frequency: _____ Type: _____ Frequency: _____

EMERGENCY CONTACT

Name: _____ Relation: _____ Contact: _____

Patient Signature: _____ Date: _____