

HISTORY

Date: \_\_\_\_\_

Patient/Acct #: DOB: For Office Use Only
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**Primary Care Physician:** \_\_\_\_\_

**Date of Onset of Pain:** \_\_\_\_\_ **Date of Injury:** \_\_\_\_\_ **Date of Surgery:** \_\_\_\_\_

**Is this an injury a result of a Motor Vehicle Accident or part of a 3<sup>rd</sup> party claim?** \_\_\_\_\_

**Medical History**

	Yes/No		Yes/No
Heart Condition	Y / N	Previous Surgeries	Y / N
Cancer	Y / N	<i>Please describe (Date/Surgical Area):</i> _____	
Stroke	Y / N		
Seizures	Y / N	Previous Back Pain	Y / N
Diabetes	Y / N	<i>Please describe (Date/Surgical Area):</i> _____	
Pregnant	Y / N		
Asthma	Y / N	Previous Neck Pain	Y / N
Osteoporosis	Y / N	<i>Please describe (Date/Surgical Area):</i> _____	
Arthritis	Y / N		
		Any Other Medical History: _____	

**Diagnostics:** \_\_\_\_\_

**Medications**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies to Medications**

\_\_\_\_\_  
\_\_\_\_\_

**Sports/Hobbies**

\_\_\_\_\_  
\_\_\_\_\_

**Occupation:** \_\_\_\_\_

<b><i>Does it include:</i></b>	Yes/No
Traveling	Y / N
Lifting (Including Children)	Y / N
Repetitive Computer or Phone Use	Y / N

**Previous Physical Therapy**

\_\_\_\_\_

**Other Treatment Interventions**

\_\_\_\_\_

**Your Goals for Physical Therapy**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

***Patient Signature*** \_\_\_\_\_