PT PLUS
PHYSICAL THERAPY
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MEDICAL HISTORY

Patient Name : _____ Date of Birth : _____ Next Dr. Apt. _____

Injury / Condition : _____ Surgery Date : _____ Onset Date : _____

Have you received physical therapy or Home Health Care via Medicare **this year**? Yes / No

Have you had any imaging performed for this condition? Please mark all that apply :

☐ X-Ray ☐ CT Scan ☐ MRI ☐ Doppler ☐ Ultrasound ☐ Bone Scan

What did they show ? _____

Have you recently noted experienced :

☐ Pregnancy / IUD
☐ Nausea / Vomiting
☐ Pain at night
☐ Numbness / Tingling
☐ Weakness
☐ Weight Loss / Gain
☐ Fatigue
☐ Headaches
☐ Insomnia
☐ Change in Vision or Hearing
☐ Fever / Chills / Sweats
☐ Cramps in Legs when Walking

Have you recently noted experienced :

☐ Cancer-Type _____
☐ PACEMAKER
☐ Fractures
☐ Seizures
☐ Loss of Consciousness / Fainting
☐ Stroke
☐ Asthma / Breathing Problems
☐ Surgeries - list below
☐ Anxiety / Depression
☐ Diabetes
☐ Heart Problems
☐ Circulation Problems / Clots
☐ Motor Vehicle Accident
☐ Sprains / Strains
☐ Leg / Ankle Swelling
☐ Urinary Problems / Infections
☐ Osteoporosis
☐ NONE APPLY TO ME
☐ Blood Pressure Problems
☐ Hearing Difficulties
☐ Lung Disease
☐ Allergies / Skin Sensitivity
☐ Easy Bruising / Bleeding
☐ Indigestion / Heartburn
☐ > 2 Falls in the last year
☐ Latex Allergy

☐ Any other medical conditions: _____
Explain & give approximate dates for any items indicated above _____
_____
_____

Current Pain Description - circle any that apply

Type of pain : Sharp / Burning / Aching / Tingling / Numbness / Other : _____
Rate your pain (average) on a 1-10 scale (1 = minimal 10 = severe) Pain Level : 0 1 2 3 4 5 6 7 8 9 10

Treatment Goals

What do you hope to get out of your treament? _____
_____
Is there anything else you would like to include or ask your physical therapist? _____
_____

_____ _____ _____ _____
Patient Signature Date Therapist Signature Date