Medical History Form

Name: _____ DOB: ___/___/____

Occupation: _____

Leisure Activities: _____

Current Height: _____ Current Weight: _____

What are you seeking treatment for today? _____

Date of injury or onset: ___/___/____ Date of Surgery: ___/___/____

Circle if you had a recent: X-ray MRI CT Scan Another Test: _____

Please list current medical conditions and any past injuries or surgeries with dates:

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Please list/attach a list of your current medications, vitamins or supplements:

1._____ 4. _____

2._____ 5. _____

3._____ 6. _____

Please list any allergies to medication or any other allergy you have:

_____

Are you latex sensitive? Yes NO

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? Yes No

During the past month have you been feeling down, depressed or hopeless? Yes No

During the past month have you been bothered by having little interest or

Pleasure in doing things? Yes No

Do you ever feel unsafe at home? Yes No

Has anyone hit you or tried to injure you in any way? Yes No

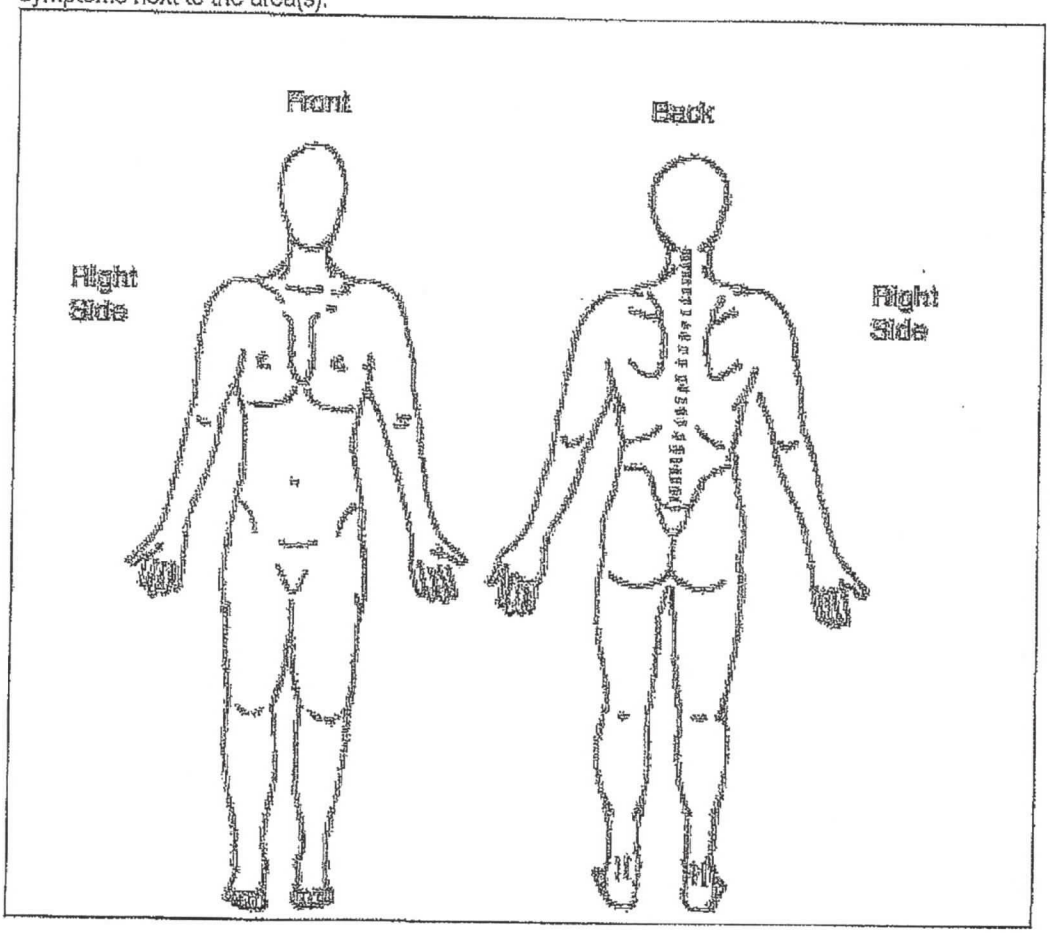
Please check all conditions that apply to your past or onset:

__Cancer
__High blood pressure
__Circulatory problems
__Blood clots
__Weight gain/loss
__Thyroid problems
__Stroke/TIA
__Asthma
__Osteoporosis
__Arthritis
__Depression
__Multiple Sclerosis
__Hepatitis
__Headache
__Stomach ulcers
__Chemical dependency
__Falls in the past year
__Heart Problems
__Diabetes
__Seizures
__Kidney disease
__Fatigue/Energy loss
__Balance issues/dizziness
__Loss of bowel or bladder control
__Numbness/Tingling
__Other_____

Evergreen Physical Therapy Specialists, PC

Patient Name:_____ Date:____/____/____
mm dd yy

Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Please include a description such as pain, tingling, numbness, burning, aching or shooting symptoms next to the area(s).



Please circle your **CURRENT** level of pain:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Please circle your **WORST** level of pain in the last 24 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain

Please circle your **BEST** level of pain in the last 24 hours:
No pain 0 1 2 3 4 5 6 7 8 9 10 worst pain