The Wellness Center at Bayside

"Add Years to Your Life, Add Life to Your Years"

Medical History Form

Please take the time to thoroughly complete this form. Your history is important for developing your treatment plan.

Name _____ Date of Birth _____

Physician/Provider Name _____ Phone # _____

Date of Injury _____ **Date of Surgery** _____ **Type of Accident** _____

What is your reason for coming to physical therapy? _____

Have you been treated for this condition prior to today? _____ YES _____ NO

If so, what type of treatment(s) have you received _____

Please list all medications you are currently taking: _____

_____

_____

If more space needed, please use back of this form.

Are you allergic to any medications? _____

Do you have a history of any of the following:

____ Bone/joint disorder	_____ Back pain	_____ Neck pain	_____ Shortness of Breath
____ High blood pressure	_____ Seizures	_____ Diabetes	_____ Asthma
____ Heart problems	_____ Dizziness	_____ Cancer	_____ Headaches
____ Bladder problems	_____ Arthritis	_____ Pacemaker	_____ Anemia
____ Bowel problems	_____ Stress/tension	_____ Depression	

Other _____

Females Only: Are you pregnant, planning a pregnancy, or nursing a child? _____ YES _____ NO

Please list recent hospitalization/surgeries: _____

_____

Are you currently working? _____ YES ____ NO

(If no, what is your last day worked? _____)

Occupation: _____

Hrs/day worked _____ Days/Week _____

What is your current activity level?

_____ Lying _____ Sitting _____ Standing

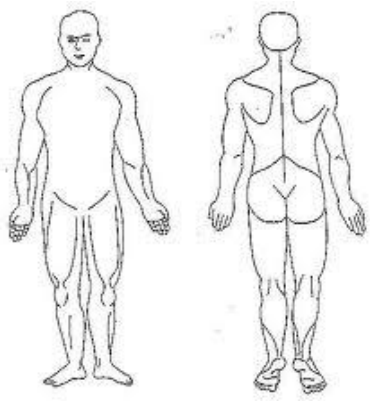
_____ Walking _____ Physical Labor

_____ Recreation/Exercise

Has your physician/provider put you on lifting restrictions?

____ YES ____ NO

Draw on diagram where you are experiencing pain



Rate your pain:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN WORST PAIN

In your best words, describe your pain/ailment: _____

Patient Signature _____ Date _____

Providers Initials _____ Date _____