1st Choice
PHYSICAL THERAPY

1st Choice is Your Best Choice!

Medical History Form

Client Name_____ Date_____

Occupation_____ Date of next physician's visit_____

Date of Injury/Surgery_____ Have you ever had these symptoms before? ☐ Yes ☐ No

Check which apply to your current condition:

☐ Work related injury ☐ Recurrence of previous injury ☐ Injury related to falling

☐ Motor vehicle accident ☐ Injury related to lifting ☐ Other

☐ Cause unknown ☐ Athletic/recreational injury

Have you ever had a related surgery? ☐ Yes ☐ No

Do you have, or have you had, any of the following:

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
Chest Pain/Angina	☐	☐	Allergies to Heat	☐	☐
High Blood Pressure	☐	☐	Allergies/Poor Tolerance to Cold	☐	☐
Heart Disease	☐	☐	Other Allergies	☐	☐
Heart Attack	☐	☐	Hernia	☐	☐
Heart Palpitations	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness/Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fractures	☐	☐
Are you Pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Nausea/Vomiting	☐	☐
Bowel/Bladder Abnormalities	☐	☐	Ringing in your Ears	☐	☐
Urine Leakage	☐	☐	Rheumatoid Arthritis	☐	☐
Asthma/Breathing Difficulties	☐	☐	Stroke/CVA	☐	☐
Liver/Gallbladder Problems	☐	☐	Hypoglycemia	☐	☐
Smoking	☐	☐	Depression	☐	☐
Other_____	☐	☐	Anxiety	☐	☐

If yes on any of the above, please briefly explain and give approximate dates: _____

_____

_____

Is there any other information regarding your past medical history that we should know about?

_____

_____

List current medications (prescriptions, over the counter, herbals, vitamin/mineral/dietary supplements) including name, dosages, frequency and route.

_____

_____

_____

_____

_____

_____

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No

Emergency Contact Information:

Name_____ Telephone_____

Relationship_____

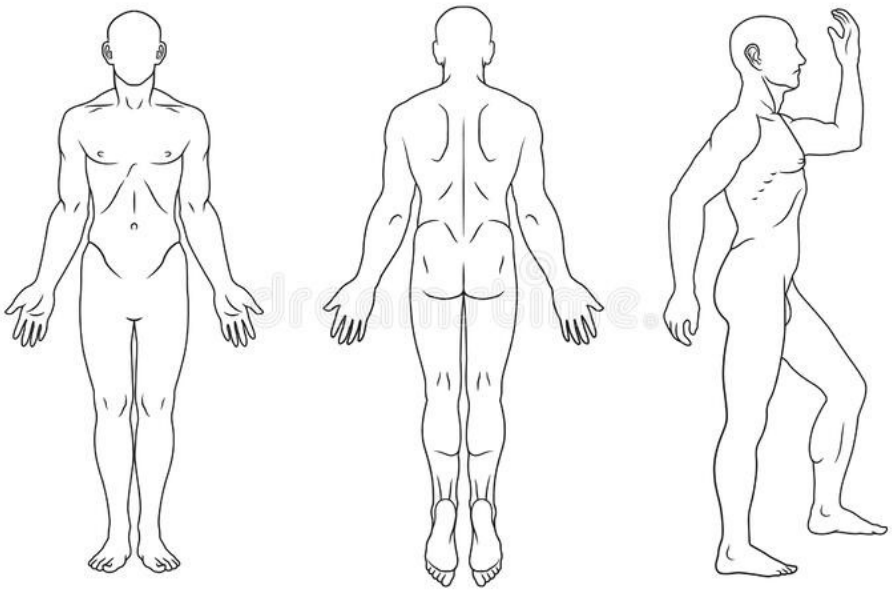
(Spouse, Mother, Father, Sister, Brother, Guardian, Other, Unknown)

Please describe the problem for which you are coming to physical therapy and the history of that problem:_____

_____

_____

Please indicate on the pictures below where your symptoms are located:



☐ Right Side ☐ Left Side ☐ Both

What was your level of function before your problem occurred (regular exercise, hobbies, activity level)? _____

_____

What are your goals for physical therapy? _____

_____

Numeric Pain Rating Scale – Please circle appropriate answer

1. How would you rate your pain RIGHT NOW?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

2. How would you rate your USUAL level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

3. How would you rate your BEST level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

4. How would you rate your WORST level of pain during the last week?

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain Imaginable

_____ _____
Client's Signature Date

_____ _____
Signature of Guardian if Client is a Minor Date

_____ _____
Therapist Signature Date