

Howard County Physical Therapy and Sports Rehabilitation
MEDICAL HISTORY

PATIENT'S NAME: _____ TODAY'S DATE: _____

HAVE YOU EVER BEEN SEEN BY A PHYSICAL THERAPIST? YES / NO

IF YES, CONDITION & DATES TREATED: _____

HAVE YOU EVER BEEN SEEN BY A CHIROPRACTOR? YES / NO

IF YES, CONDITION & DATES TREATED: _____

MEDICAL HISTORY

Have you ever had:

- | | | |
|------------------------------|--------------------------|----------------------------------|
| _____ Allergies | _____ Dizziness | _____ High Blood Pressure |
| _____ Arthritis | _____ Epilepsy | _____ Loss of Sensation |
| _____ Arterial Disease | _____ Fatigue | _____ Lung Disease |
| _____ Asthma | _____ Fractures | _____ Operations (explain below) |
| _____ Back or Joint Problems | _____ Headaches | _____ Osteoporosis |
| _____ Back Pain | _____ Hearing Loss | _____ Pregnancy |
| _____ Chest Pain | _____ Heart Palpitations | _____ Shortness of Breath |
| _____ Diabetes | _____ Heart Problems | _____ Swollen Legs |

Have you had cancer? Yes / No What type? _____

Other medical conditions, pertinent medical history or details about above _____

Do you participate in any physical activities or sports? Yes / No What type? _____

Do you smoke? Yes / No If yes, how much per day? _____

Average hours of sleep per night? _____ Restlessness? Yes / No Do you awake refreshed? Yes / No

Height _____ Current Weight _____ Desired Weight _____ Are you dieting? Yes / No

Current Medications: _____

Have you fallen in the past year? YES NO If yes, how many times have you fallen? _____

Describe the circumstances of the fall. _____

Did you sustain an injury when you fell and if so, please explain? _____

Therapist Comments: _____
