

# Mady and Mules 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: \_\_\_\_\_

### **MEDICAL HISTORY**

Have you ever had:

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

Do you currently have Internal Devices (i.e. pacemaker)? \_\_\_\_\_

Have you had cancer? Yes / No What type? \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Have you had a sudden weight loss or gain? Yes / No

Do you smoke? Yes / No

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 currently have a gym membership? Yes / No Are you working with a personal trainer? 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? \_\_\_\_\_

\_\_\_\_\_

Reviewed: \_\_\_\_\_ (P.T.'s initials)

Therapist Comments: \_\_\_\_\_

\_\_\_\_\_

Information will be reviewed and discussed with patient and the information will be incorporated into the goals and plan of care established in collaboration with the patient.