



### PAST MEDICAL HISTORY FORM

Patient Name \_\_\_\_\_

BLOOD PRESSURE			JOINT CONDITIONS		
	YES	NO		YES	NO
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Upper Extremity	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Normal Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Lower Extremity Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
HEART DISEASE			OTHER CONDITIONS		
	YES	NO		YES	NO
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Atherosclerotic Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial Infarction	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Gout	<input type="checkbox"/>	<input type="checkbox"/>
MUSCLE CONDITION			Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
	YES	NO	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Carpal Tunnel R/L	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Tennis Elbow R/L	<input type="checkbox"/>	<input type="checkbox"/>	Poor Eyesight	<input type="checkbox"/>	<input type="checkbox"/>
Back/Neck Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Limited Limb Movement	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS			Other: _____		
	YES	NO	_____		
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____		

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS	
<input type="checkbox"/> None	<input type="checkbox"/> Sitting	<input type="checkbox"/> Low	<input type="checkbox"/> Smoking	Packs a Day _____
<input type="checkbox"/> 1-2 x Week	<input type="checkbox"/> Standing	<input type="checkbox"/> Medium	<input type="checkbox"/> Alcohol	Drinks a Week _____
<input type="checkbox"/> 3-4 x Week	<input type="checkbox"/> Light Labor	<input type="checkbox"/> High	<input type="checkbox"/> Coffee/Soda	Cups a Week _____
<input type="checkbox"/> 5+ x Week	<input type="checkbox"/> Heavy Labor			

What types of exercise do you perform? : \_\_\_\_\_

What things cause stress in your life? : \_\_\_\_\_

Are you taking any seizure medication?  YES  NO If yes list name: \_\_\_\_\_

Are you taking any medications that might affect your lungs, heart, consciousness or general well-being while participating in therapy?  
 YES  NO If yes list name: \_\_\_\_\_

List all medications you are currently taking: \_\_\_\_\_

List all surgeries in the past two years (Including dates): \_\_\_\_\_

Are you pregnant?  YES  NO What week?: \_\_\_\_\_

Have you had any injuries related to work?  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had any Auto Accidents  YES  NO If yes list body part and date.: \_\_\_\_\_

Have you had Physical Therapy or Massage Therapy before?  YES  NO Where: \_\_\_\_\_

Signature of Patient, Parent, Guardian, Personal Representative

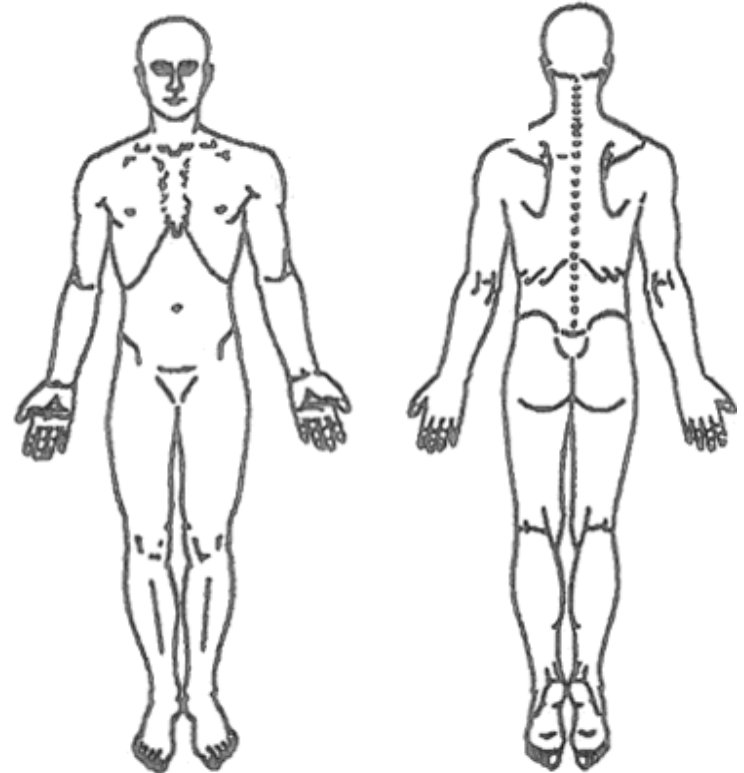
Date

# Pain and Symptom Status Report

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Using the symbols below, please draw at the location on the body outlines, the type of pain you are experiencing



- |   |                             |                               |
|---|-----------------------------|-------------------------------|
| <b>Ache</b><br>MMM<br>M                                       | <b>Burning</b><br>---<br>-- | <b>Numbness</b><br>OOO<br>OOO |
| <b>Pins and Needles</b><br>□ □ □ □ □ □ □ □<br>□ □ □ □ □ □ □ □ | <b>Stabbing</b><br>/////    | <b>Other</b><br>xxxx<br>xxx   |

## Chief Complaint and Visual Analog Scale

My Chief Complaint is: \_\_\_\_\_

Date First Symptom of your problem occurred on: \_\_\_\_\_

2nd Complaint: \_\_\_\_\_

3rd Complaint: \_\_\_\_\_

<b>Please circle on the scale below to indicate your <u>CURRENT</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>AVERAGE</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it
<b>Please circle on the scale below to indicate your <u>WORST</u> level of pain:</b>												
No Pain	0	1	2	3	4	5	6	7	8	9	10	Pain as bad as it

Additional Comments: \_\_\_\_\_

## Why did You Choose Us?

**Please check ALL that apply:**

- My doctor referred me to your clinic.
- I was a previous patient.
- I am a current fitness center client.
- I found out about you from a friend/family member.
- I heard about your services from one of your physical therapists.
- Your website and/or the search engines (Google, Yahoo!, MSN, Live) influenced my choice to come to your clinic.
- I learned about your services from an email newsletter.
- I found you in my insurance preferred provider booklet.
- I found you in the Yellow Pages.
- Other \_\_\_\_\_