

St. Louis Physical Therapy

PATIENT MEDICAL HISTORY

Name:	Referring Physician:
Family Physician:	Date of first doctor visit for this injury:
Last date worked due to injury:	Date returned to work following injury:

Is an Attorney involved in this case? YES NO
 Have you had surgery for **this injury**? YES NO Number of surgeries _____
 Type of Surgery _____ Took place in: Hospital Surgery Center

Are you currently taking any prescription or non-prescription medications? YES NO
 Please check any medications you are taking:
 _____ Anti-inflammatories _____ Pain Medication
 _____ Muscle Relaxants _____ Other: _____

Have you had any of the following Medical or Rehabilitative services for this injury/episode? (Please check)

_____ Chiropractor	_____ X-rays	_____ Physical Therapy
_____ General Practitioner	_____ MRI	_____ Occupational Therapy
_____ Neurologist	_____ CT scan	_____ Massage Therapy
_____ Orthopedist	_____ EMG/NCV	_____ Emergency Room Care
_____ Podiatrist	_____ Myelogram	_____ Other: _____

Do you currently or have you ever had any of the following? (Please check all that apply)

_____ Allergies	_____ Emboli	_____ Osteoporosis
_____ Anemia	_____ Emphysema	_____ Pins or metal implants
_____ Angina	_____ Emotional problems	_____ Psychological problems
_____ Arthritis	_____ Energy Loss	_____ Severe Headaches
_____ Asthma	_____ Epilepsy	_____ Seizures
_____ Bladder problems	_____ Frequent fainting	_____ Shortness of breath
_____ Blood Clot	_____ Goiter	_____ Sleeping problems
_____ Bowel Problems	_____ Gout	_____ Stroke
_____ Bronchitis	_____ Hearing difficulties	_____ Swollen joints
_____ Cancer	_____ Heart attack/problems	_____ Thyroid trouble
_____ Chemotherapy/Radiation	_____ Heart surgery	_____ Varicose veins
_____ Chest pain	_____ Hernia	_____ Vision difficulties
_____ Coronary Heart Disease	_____ High Blood Pressure	_____ Weakness
_____ Diabetes	_____ Joint Replacement	_____ Weight loss
_____ Dizziness	_____ Numbness/Tingling	

Do you have a pacemaker? YES NO Have you ever had an injury or surgery on any of the following?
 Do you smoke? YES NO
 Are you pregnant? YES NO

	Injury	Surgery		Injury	Surgery
Foot	_____	_____	Hand/Wrist	_____	_____
Ankle	_____	_____	Elbow	_____	_____
Knee	_____	_____	Shoulder	_____	_____
Back	_____	_____	Neck	_____	_____

List any other information that would assist us in your care: _____

Are you aware of your diagnosis? YES NO Are you in need of a social service consult? YES NO

What are your goals for this rehabilitation program? _____

Patient/Guardian Signature: _____ Date: _____