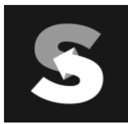

SYMMETRY
PHYSICAL THERAPY

PATIENT MEDICAL HISTORY

Patient Name ________________________________ Referring Physician: ________________________

Occupation: ________________________________ Family Physician: ________________________

Date of Injury / Episode Onset: __________________ Was any work missed due to this episode? Y / N

Have you had Surgery **on this body part**? ☐ Yes ☐ No Type of Surgery: ____________________________

If applicable, date of surgery: ____________________ Is an Attorney involved in this case? ☐ Yes ☐ No

Pain Levels: Please rate your pain on a scale of 0 (no pain) to 10 (excruciating pain) for each of the following:

Current Level: 0 1 2 3 4 5 6 7 8 9 10 At Best: 0 1 2 3 4 5 6 7 8 9 10 At Worst: 0 1 2 3 4 5 6 7 8 9 10

Are you currently taking any prescription or non-prescription medications? ☐ **Yes** ☐ **No**

- ☐ Drug Name / Dosage: ____
- ☐ Drug Name / Dosage: ____
- ☐ Drug Name / Dosage: ____
- ☐ Drug Name / Dosage: ____

Have you had any of the following medical or rehabilitative services for this Injury/Episode?

	YES	NO			YES	NO
Chiropractor				CT Scan		
EMG/NCV				General Practitioner		
Massage Therapy				MRI		
Myelogram				Neurologist		
Occupational Therapy				Orthopedist		
Physical Therapy				Podiatrist		
Emergency Room Care				X-rays		
Other						

Do you now have, or have you ever had any of the following?

	YES	NO			YES	NO
Asthma, bronchitis, emphysema				Severe or frequent headaches		
Shortness of breath?chest pain				Vision or hearing difficulties		
Coronary Artery Disease				Numbness or tingling		
Pacemaker				Dizziness or fainting		
High blood pressure				Ringing in your ears		
Heart attack or heart surgery				Weakness		
Stroke / TIA				Weight loss / Energy Loss		
Blood clot / emboli				Hernia		
Epilepsy / seizures				Tuberculosis		
Thyroid trouble / Goiter				Allergies		
Anemia				Any pins or metal implants		
Infectious diseases				Joint replacement		
Diabetes				Neck injury / surgery		
Cancer/Chemotherapy/ Radiation				Shoulder injury / surgery		
Arthritis / Swollen Joints				Elbow/hand injury/surgery		
Osteoporosis				Back injury / surgery		
Gout				Knee injury / surgery		
Sleeping problems				Leg/ankle/foot injury/surgery		
Emotional/psychological problems				Are you pregnant?		
Bowel or Bladder Problems				Do you smoke?		

What is your estimated height? __________________ **What is your estimated weight?** __________________

What are your expectations/goals for therapy? ____

Patient / Guardian Signature **Date**
____