MEDICAL HISTORY

Patient Name: ________________________________ **Date:** _________________

Height: ______________ ***Weight***: ______________ ***Age***: ______________

Do you have (*or have had*) any of the following Medical Conditions?
Please note Date of 1st Occurance

☐ Cancer (*Type*) __________________	☐ Blood clots _______________
☐ Heart problems __________________	☐ High blood pressure _______________
☐ Stroke __________________	☐ High Cholesterol _______________
☐ Diabetes __________________	☐ Anemia _______________
☐ Pacemaker __________________	☐ Circulation problems_______________
☐ Osteoarthritis __________________	☐ Bone/Joint Infection _______________
☐ Osteoporosis __________________	☐ Other __________________________

Mental Health (check box)
Have you ever been diagnosed with Depression or Bipolar Disorder? ☐ Yes or ☐ No

Fall (check box)
Have you had any falls within the last 12 months? ☐ Yes or ☐ No
If yes, how many? _____

Have any resulted in injury? ☐ Yes or ☐ No

Surgical History (*please indicate date*)

☐ Heart Procedure ________________	☐ Cancer Removal ________________
☐ Back Surgery ________________	☐ Total Hip Replacement (L/ R) ________
☐ Shoulder Surgery ________________	☐ Total Knee Replacement (L/ R) _______
☐ Neck Surgery ________________	☐ Other ________________________
☐ Knee Surgery ________________	

List any Medications you are currently taking (*including: vitamins, injections or other*)

Name	**Reason**	**Dosage**	**Frequency:** (Circle)	**Type** (Circle)
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject
________________	___________	_________	1/Day 2/Day 3/Day or As Needed	Oral/Inject

Are you a Tobacco user? (check box) ☐ Yes or ☐ No

MEDICAL HISTORY

Treatments Related to Current Condition	Start Date	End Date	Improved
Home Health	___________	___________	Y N
Primary Physician	___________	___________	Y N
Orthopedic Surgeon	___________	___________	Y N
Physical Therapy	___________	___________	Y N
Diagnostic Imaging (MRI, X-ray)	___________	___________	Y N
Chiropractor	___________	___________	Y N
Neurologist	___________	___________	Y N
Physiatrist	___________	___________	Y N
Massage	___________	___________	Y N
Other ________________________	___________	___________	Y N

Have you been discharged from the hospital, a skilled nursing facility, or Home Health Agency within the past 30 days? ☐Yes ☐No If Yes, please describe: ________________

____

Pain Rating Scale

Please mark a place on the scale that best describes your worst level of pain.