

Patient Medical Information/Problem Sheet

	<u>Existing Medical Conditions</u>	<u>Medications Prescribed</u>	<u>Treating MD</u>	<u>Therapist Initials</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

<u>List previous injuries/surgeries/hospitalizations and dates of occurrence</u>	<u>Therapist Initials</u>
_____ Date: _____	_____
_____ Date: _____	_____
_____ Date: _____	_____
_____ Date: _____	_____
_____ Date: _____	_____

<u>Allergies/Adverse Drug Reactions:</u>	<u>Therapist Initials</u>
_____	_____

IV. Other related conditions

Check all that apply if you have had a history of:

- | | | |
|---|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stroke/CVA | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Cardiac disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Swallowing Problems |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Current pregnancy | <input type="checkbox"/> Recent falls |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Recent flu/fever | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Bowel/Bladder changes | <input type="checkbox"/> Chronic headaches | <input type="checkbox"/> Vascular/Circulatory disease |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Liver/kidney problem | |
| <input type="checkbox"/> Asthma/Respiratory Disorders | <input type="checkbox"/> Nervous disorder | |
| <input type="checkbox"/> Metal implants | <input type="checkbox"/> Bone disease/fractures | |
| <input type="checkbox"/> Smoking | <input type="checkbox"/> Hernia | |
| <input type="checkbox"/> Other: _____ | | |

I hereby certify that I am taking only the medications listed.
Signature: _____



TURN OVER

PATIENT INFORMATION

Name: _____ Date: _____
Occupation: _____ Job Duties: _____
Leisure Activities: _____ Age: _____

Please answer each question concisely:

What date did the problem start? _____

Was it due to an *injury* or a *surgery* (please circle one)

What is your major complaint? _____

Briefly state previous treatment, if any: _____

Do you have numbness and/or tingling? _____ Where? _____

Rate your overall daily pain: **(No pain=0)** 0 1 2 3 4 5 6 7 8 9 10 **(10=worst possible pain)**

Does your pain interrupt your sleep? YES _____ NO _____

If yes, do you easily return to sleep? YES _____ NO _____

What is your pain like in the morning? _____

What is your pain like in the evening? _____

What makes your pain/symptoms worse? _____

What makes your pain/symptoms better? _____

Are you taking medications for this problem? YES _____ NO _____

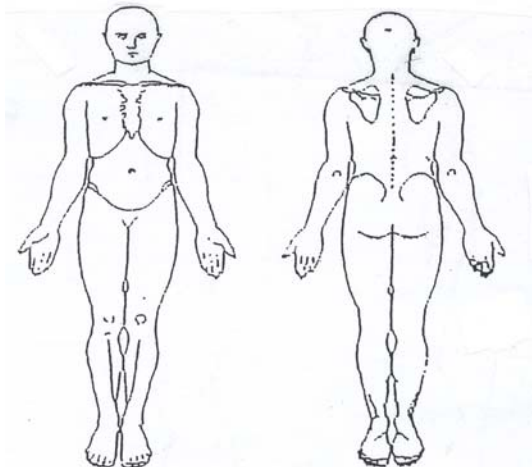
If yes, please list: _____

Have you had any X-rays, CAT scans, MRIs or other diagnostic tests for your disorder?

YES (please list): _____ NO _____

What are your goals for therapy? _____

PLEASE DARKEN IN THE AREAS OF YOUR PAIN/SYMPTOMS ON THE BODY CHART



TURN OVER

