GINDI PHYSICAL THERAPY

PATIENT MEDICAL HISTORY FORM

Name: ______________________

Family Physician: ______________________

Last Day Worked Due to this Injury: ______________________

Is an attorney involved in this case

Treating Physician: ______________________

Date of 1st Doctors Visit For this Injury: ______________________

Date Returned to Work After Injury: ______________________

Were you referred to Professional PT by

List if other: ______________________

Have you had Surgery for this Injury?

Number of Surgeries

Type of Surgery: ______________________

Are You Currently Taking Any Prescription or Non-Prescription Medications. (Please List Below)

Anti-Inflammatories ______________________

Muscle Relaxers ______________________

Pain Medication ______________________

Other ______________________

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	☐	☐	General Practitioner	☐	☐
EMG/NCV	☐	☐	CT Scan	☐	☐
Massage Therapy	☐	☐	MRI	☐	☐
Milligram	☐	☐	Neurologist	☐	☐
Occupational Therapy	☐	☐	Orthopedist	☐	☐
Physical Therapy	☐	☐	Podiatrist	☐	☐
Emergency Room Care	☐	☐	X-Rays	☐	☐

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

	YES	NO		YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	☐	☐	High Blood Pressure	☐	☐	Anemia	☐	☐
Shortness of Breath/Chest Pain	☐	☐	Heart Attack or Surgery	☐	☐	Diabetes	☐	☐
Coronary Heart Disease or Angina	☐	☐	Thyroid Trouble/Goiter	☐	☐	Gout	☐	☐
Cancer/chemotherapy/Radiation	☐	☐	Dizziness or Fainting	☐	☐	Weakness	☐	☐
Emotional/Psychological Problems	☐	☐	Infectious Diseases	☐	☐	Hernia	☐	☐
Bowel or Bladder Problems	☐	☐	Numbness or Tingling	☐	☐	Allergies	☐	☐
Severe or Frequent Headaches	☐	☐	Elbow/Hand Injury	☐	☐	Osteoporosis	☐	☐
Vision or Hearing Difficulties	☐	☐	Neck Injury/Surgery	☐	☐	Stroke/TIA	☐	☐
Sleeping Problems/Difficulties	☐	☐	Back Injury/Surgery	☐	☐	Blood Clot/Emboli	☐	☐
Leg/Ankle/Foot Injury/Surgery	☐	☐	Knee Injury/Surgery	☐	☐	Epilepsy/Seizures	☐	☐
Do you have a Pacemaker?	☐	☐	Arthritis/Swollen Joints	☐	☐	Varicose Veins	☐	☐
Any Pins or Metal Implants?	☐	☐	Are You Pregnant?	☐	☐	Joint Replacement	☐	☐
Weight Loss/Energy Loss	☐	☐	Do You Smoke?	☐	☐			

List any other information that would assist us in your care? ______________________

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Are you aware of what your diagnosis is (what you're being treated for)?

Based upon your awareness, what are your expectations/goals while in this program? ______________________

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Patient/Guardian Signature: ______________________

Date: ___/___/___