Crossroads Physical Therapy

Medical History Form

Patient's Name: _____Preferred name (nickname):_____ Date: _____

1. What is the primary complaint/injury for which you are seeking physical therapy?

   _____

   _____

2. When did your pain/dysfunction begin? Was there an injury or did it come on gradually? Describe this incident.

   _____

   _____

3. Please rate your pain for your current condition 0-10, 0 = no pain, 10 = worst imaginable pain.

   Current:

   0 1 2 3 4 5 6 7 8 9 10

   At its worst:

   0 1 2 3 4 5 6 7 8 9 10

4. What are the top three activities that your injury/dysfunction are currently limiting (i.e. walking, standing, lifting, reaching, personal care, sleeping, driving, work tasks, etc.)

   a. _____

   b. _____

   c. _____

5. What makes your pain/dysfunction better? (medication, ice, heat, rest) _____
6. What makes your pain/dysfunction worse? (activity, body positions, time of day) _____
7. Have you ever had injury to the following areas? **If yes, please specify.**

   Neck/Head (including whiplash and concussion) _____

   Trunk (ribs, vertebrae, sternum) _____

   Low Back (vertebrae, discs, nerves) _____

   Upper Extremity (Shoulder, elbow, wrist, hand) _____

   Lower Extremity (hip, knee, ankle, foot) _____

8. Have you ever, or are you presently being treated for any of the following? **If yes, please describe.**

Anxiety or Panic Disorder	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Concussion/Whiplash	☐ Yes	☐ No
Hearing impairment (hearing aid, deafness)	☐ Yes	☐ No
Visual impairment (glasses, contacts, glaucoma, cataracts, double vision)	☐ Yes	☐ No
Headaches or Migraines	☐ Yes	☐ No

Sinus Issues	☐ Yes	☐ No
Dental /Jaw Issues (orthodontia, night guard, TMJ disorder, grinding)	☐ Yes	☐ No
Dizzy or Fainting Spells (including vertigo, BPPV, Meniere's Disease)	☐ Yes	☐ No
Ringing in ears (tinnitus)	☐ Yes	☐ No
Thyroid issues (hypothyroid, hyperthyroid, Hashimoto's Disease, Grave's Disease)	☐ Yes	☐ No
Stroke or Transient Ischemic Attack (TIA)	☐ Yes	☐ No
Epilepsy or Seizure Disorder	☐ Yes	☐ No
Neurological Disorder (Parkinson's Disease, Multiple Sclerosis, ALS, Spinal cord injury)	☐ Yes	☐ No
Postural Orthostatic Tachycardia Syndrome (POTS)	☐ Yes	☐ No
Respiratory Condition (COPD, Acquired Respiratory Distress Syndrome, asthma, emphysema)	☐ Yes	☐ No
Smoking	☐ Yes	☐ No
Heart Condition (Congestive Heart Failure, heart attack, angina, pacemaker)	☐ Yes	☐ No
Peripheral Vascular Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Nausea/Vomiting (please specify circumstances)	☐ Yes	☐ No
Upper Gastrointestinal Disease (ulcer, hernia, reflux/GERD)	☐ Yes	☐ No
Hernia (hiatal, inguinal)	☐ Yes	☐ No
Kidney issues	☐ Yes	☐ No
Liver/Gallbladder issues	☐ Yes	☐ No
Bowel/Bladder Abnormalities (incontinence, difficulty initiating)	☐ Yes	☐ No
Lower Gastrointestinal Disease (diverticulosis, IBS, Ulcerative Colitis/Crohn's Disease)	☐ Yes	☐ No
Pregnancy (please specify how many and dates)	☐ Yes	☐ No
Sexual Dysfunction	☐ Yes	☐ No
Pelvic Issues (enlarged prostate, endometriosis, ovarian cyst)	☐ Yes	☐ No
Altered sensation in hands/feet (numbness/tingling, neuropathy)	☐ Yes	☐ No
Back Condition (Degenerative Disc Disease, Spinal stenosis, spinal fracture)	☐ Yes	☐ No
Osteopenia or Osteoporosis	☐ Yes	☐ No
Arthritis (Rheumatoid Arthritis, osteoarthritis)	☐ Yes	☐ No
Fracture (please specify where)	☐ Yes	☐ No
Metal Implants (please specify where)	☐ Yes	☐ No
Connective Tissue Disorder (Ehlers-Danlos Syndrome (EDS), scleroderma, lupus, hypermobility)	☐ Yes	☐ No

Skin Abnormalities (psoriasis, eczema)	☐ Yes	☐ No
Allergies (seasonal, food, latex)	☐ Yes	☐ No
Autoimmune Disorder	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Hypoglycemia	☐ Yes	☐ No
Cancer (please specify what kind/where)	☐ Yes	☐ No
Balance/Coordination Problems	☐ Yes	☐ No

9. Please list current medications: _____
_____
10. Please list any surgeries that you have had and their dates: _____
_____
11. Please list any injections, what kind, and for what body part: _____
_____
12. Please list if you have an imaging you have had (x-ray, CT scan, MRI), and for what body part: _____
_____
13. What specialists are you currently seeing/have seen for the condition you are coming in for today? (physical therapist, orthopedist, chiropractor)_____
14. What specialists are you currently seeing/have seen for other conditions (rheumatologist, urologist, cardiologist, oncologist)_____
15. What is your goal for therapy at this time? (Reduce pain, resume a specific activity, gait strength/flexibility, education, injury prevention, etc.) _____
_____
16. On a scale from 0 to 10, how would you rate your investment in your rehabilitation, with 0 = not ready, willing, or able to invest and 10 = very ready, willing, and able to invest.

0 1 2 3 4 5 6 7 8 9 10