

Medical History Disclosure Form

Patient Name: _____ Date: _____

Height: _____ Weight: _____ Employer: _____ Job Title: _____

Accident Related? No Yes If Yes: Auto Work Sports Other: _____

(If Work Comp) Contact at your work: _____ Ph#: _____

Do you currently have an attorney for THIS ACCIDENT/INJURY? No Yes, Attorney's Name: _____

Side of Injury: N/A Left Side Right Side

Injury Date/Onset Date: _____

Surgery performed on this injury? No Yes, date of surgery: _____ type of surgery: _____

Have you been hospitalized within the past year? No Yes, dates of hospitalization: _____

How did injury happen? _____

Where did injury happen? _____

Main Reason for needing therapy: _____

Mark your pain level:

	0=No Pain			5=Moderate Pain				10=Extreme Pain			
	0	1	2	3	4	5	6	7	8	9	10
At Worst:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Current:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
At Best:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Describe pain:

Burning Sharp Dull/Achy Throbbing Shooting Numbness/Tingling

Constant Intermittent Worse in AM Worse in PM Worse at Night

Does any of the following aggravate your injury?

Sitting Standing Walking Stairs-Up Stairs-Down

Sit to Stand Bending Voiding Lying Down Cough/Sneeze

What makes your pain worse? _____

What makes your pain better? _____

Have you ever had this injury/pain before? No Yes, please explain: _____

Please rate your general health: Good Fair Poor

Please mark your social history:

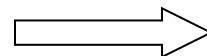
Lives at Assisted Living Facility Lives with Family Lives with Caregiver

Married Single

What is your occupation? _____ Full Time Part Time

Duty Level: Sedentary Light Medium Heavy Very Heavy

Are you currently off of work? No Yes, dates: _____



Are you a tobacco user? No Yes

Are you currently receiving home health services No Yes

Do you have a history of falls? No Yes, please explain: _____

Do **YOU** have a Medical History of:

- None
- Alzheimer's
- Cardiovascular Disease
- Cauda Equina Syndrome
- Cerebral Vascular Accident
- Current Infection
- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Fibromyalgia
- Fracture or Suspected Fracture
- High Blood Pressure
- Pacemaker/Defibrillator
- Other, please explain: _____
- History of Cancer
- Huntington's
- Immunosuppression
- Lupus
- Muscular Dystrophy
- Obesity
- Osteoarthritis
- Parkinson's
- Rheumatoid Arthritis
- Traumatic Brain Injury
- Currently Pregnant (Due Date) _____

Have you had any of the following tests for this injury?

- X-ray
- MRI
- CT Scan
- Myelogram
- EMG

Findings: _____

Have you had any previous Physical Therapy, Chiropractic Treatments, or Occupational Therapy for this injury?

No Yes, please explain: _____

Have you had recent unexplained weight loss? No Yes, please explain: _____

Please list all **current medications with dosage**:

- Prescription: _____
- Over the Counter: _____
- Herbal: _____
- Vitamin/Mineral/Dietary Supplements: _____
- Other: _____
- Not currently taking any medications