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:	○	○	○	○	○	○	○	○	○	○	○
Current:	○	○	○	○	○	○	○	○	○	○	○
At Best:	○	○	○	○	○	○	○	○	○	○	○

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

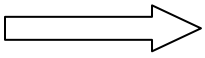
Please mark your social history:

○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
○ History of Cancer
○ Huntington's
○ Immunosuppression
○ Lupus
○ Muscular Dystrophy
○ Obesity
○ Osteoarthritis
○ Parkinson's
○ Rheumatoid Arthritis
○ Traumatic Brain Injury
○ Currently Pregnant (Due Date) _____
○ Other, please explain:_____

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