Redbud Health Services
Physical Therapy

PAST MEDICAL HISTORY FORM

Patient Name: _____ Date: _____

Are you presently working? ☐ Yes Occupation: _____ ☐ Disabled ☐ Retired ☐ Other

Date of injury / onset: ___/___/___ Date of next physician's visit: ___/___/___
Have you ever had physical therapy for these symptoms before? ☐ Yes ☐ No
Check which apply to your symptoms:
☐ work related injury ☐ recurrence of previous injury
☐ motor vehicle accident ☐ injury related to lifting ☐ injury related to falling
☐ cause unknown ☐ athletic / recreational injury ☐ other: _____

Have you had a **related** surgery? ☐ Yes ☐ No Describe _____

Do you participate in any sports, exercise programs or activities on a regular basis? ☐ Yes ☐ No
If yes, please describe _____

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Stroke / CVA /TIA	☐	☐
Heart problems / Angina	☐	☐	Allergies to medicine	☐	☐
High Blood Pressure	☐	☐	Allergies / Poor tolerance to Cold	☐	☐
Peripheral Vascular Disease	☐	☐	Other Allergies	☐	☐
Low Blood Pressure	☐	☐	Hernia	☐	☐
Anti-coagulant Therapy	☐	☐	Seizures	☐	☐
Neurological Problems	☐	☐	Metal Implants	☐	☐
Eye / Ear problems	☐	☐	Dizziness / Fainting	☐	☐
Kidney Problems	☐	☐	Recent Fracture	☐	☐
Are you pregnant?	☐	☐	Surgeries (list below)	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis / Osteopenia	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea/ Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Special Diet Guidelines	☐	☐
Smoking	☐	☐	Hypoglycemia	☐	☐
Other:	☐	☐	Headaches	☐	☐

If yes on any of the above, please briefly explain and give approximate date:

Is there any other information regarding your past medical history that we should know about?

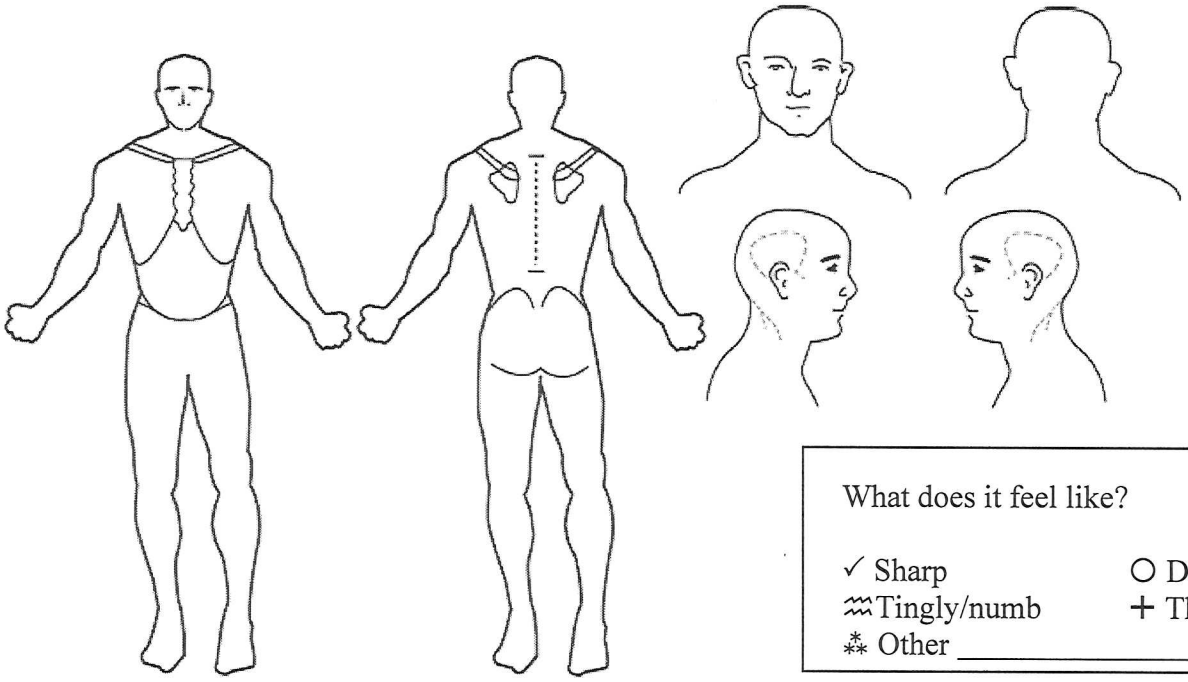
Please continue on the other side.

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications and for what condition:

Describe your current health (circle one) Poor Fair Very Good Excellent

Please indicate below where your symptoms are located.



What does it feel like?

✓ Sharp ○ Dull/Ache
≈ Tingly/numb + Throbbing
⁂ Other _____

Do these symptoms affect your sleep? ☐ No ☐ Yes Explain:_____

If your complaint includes pain, please rate the intensity of your pain on a scale of 0 to 10.
0 = no pain and 10 = worst possible pain.

What is your current level of pain? _____
What is your AVERAGE or TYPICAL pain? _____
What is your pain at its best (How close to 0 does it get at its best)? _____
What is your pain at its WORST (How close to 10 does your pain get at its worst)? ____.

_____ ____/____/___ _____
Patient's Signature Date Guardian (if patient has one)

Thank you for taking the time to provide this information.