

### Pertinent Medical History

Please include information that gives our physical therapists a picture of your current medical health.  
A safe & successful rehabilitation is our goal.

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_

#### Current Condition

List the chief medical complaint that brings you to Physical Therapy: \_\_\_\_\_

Specific Tests done:  X-ray  MRI  CAT scan  Other Test \_\_\_\_\_

Surgery(s) related to this condition: \_\_\_\_\_

Your Goals: "I would like to...." \_\_\_\_\_

Aggravating (Position/Movements/Other): \_\_\_\_\_

Relieving (Position/Movements/Other): \_\_\_\_\_

#### Current & Past Medical Conditions

(if "Yes" please specify)

- No  Yes Allergies (Latex, Tape) \_\_\_\_\_
- No  Yes Fractures \_\_\_\_\_
- No  Yes Other Injuries (joint, muscle) \_\_\_\_\_
- No  Yes Other Pain \_\_\_\_\_
- No  Yes Weakness \_\_\_\_\_
- No  Yes Back Condition \_\_\_\_\_
- No  Yes Arthritis \_\_\_\_\_
- No  Yes Swelling \_\_\_\_\_
- No  Yes Neurological Condition \_\_\_\_\_
- No  Yes Fatigue \_\_\_\_\_
- No  Yes Current Pregnancy \_\_\_\_\_
- No  Yes Kidney Condition \_\_\_\_\_
- No  Yes Stomach/Intestinal Condition \_\_\_\_\_
- No  Yes Heart Condition \_\_\_\_\_
- No  Yes Blood Vessel Condition \_\_\_\_\_
- No  Yes Skin Condition \_\_\_\_\_
- No  Yes Diabetes \_\_\_\_\_
- No  Yes Hormonal Condition \_\_\_\_\_
- No  Yes Reproductive Organ Condition \_\_\_\_\_
- No  Yes Depression \_\_\_\_\_
- No  Yes Psychiatric Condition \_\_\_\_\_
- No  Yes Recent Bleeding \_\_\_\_\_
- No  Yes Blood Condition \_\_\_\_\_
- No  Yes Bowel or Bladder Changes \_\_\_\_\_
- No  Yes Recent Weight Loss or Gain \_\_\_\_\_
- No  Yes Cancer \_\_\_\_\_
- No  Yes Infections \_\_\_\_\_
- No  Yes Drug Abuse \_\_\_\_\_

Other Medical Conditions / Surgeries: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_