PATIENT LABEL AREA

PATIENT MEDICAL HISTORY

Patient Name: ______________________________ Date: ____________

Date of next doctor appointment: ____________ When did your symptoms start? ____________

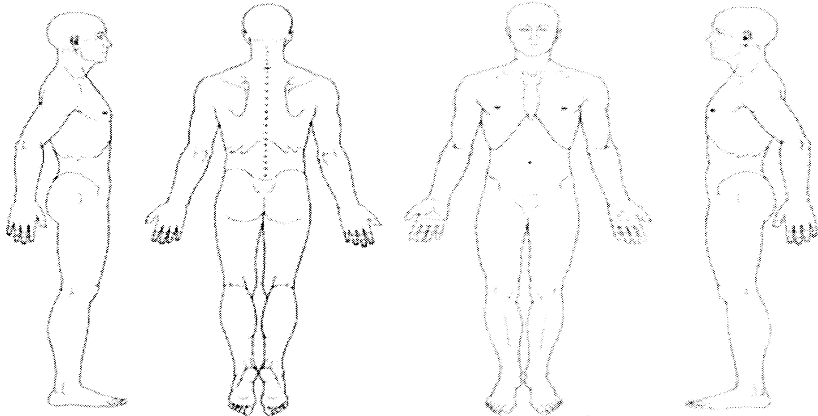
How did your symptoms begin? ______________________________

Please indicate on the body views, where you have pain and or other symptoms.

PLEASE MARK ON BODY DIAGRAM WITH /// OR XXX WHERE EACH SYMPTOM IS LOCATED.

PAIN: ///

PINS & NEEDLES: **XXXX**



Please list all medications you are presently taking. ______________________________

____

Please complete the following information regarding any special tests you have had done for this condition.

☐ MRI ☐ X-Ray ☐ CAT SCAN ☐ Other: ____________ Date completed: ____________

Have you had any of the following this year?

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy ☐ Chiropractic Care ☐ Home Care

If yes, where were you treated and for what condition? ______________________________

____

Do you suspect or are you currently pregnant? ☐ Yes ☐ No

What goals do you hope to accomplish with your physical therapy? ______________________________

____

Required To Be Completed: **What is your primary language?** ____________

What is your preferred language? ____________

Patient's Signature: ____________

FOR AUTHORIZED USE ONLY

To Be Completed By The Therapist:

Does the patient show signs of or indicate to you that they are currently experiencing any of the following:

Abuse: ☐ Yes ☐ No Neglect: ☐ Yes ☐ No Depression: ☐ Yes ☐ No Suicidal Thoughts: ☐ Yes ☐ No

Therapist's Signature: ____________

Print Name: ____________

Form No. 17041 Rev. 07/13

Date: ____________ Time: ____________

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