PHYSICAL/OCCUPATIONAL THERAPY MEDICAL HISTORY FORM

Patient:_____ **Date of Birth:**_____ **Date:**_____

1. What is your primary reason for requiring therapy services?
2. When did you notice the start of your symptoms?
3. What limitations do you currently have?
4. How would you rate your pain *at its best*? 1 2 3 4 5 6 7 8 9 10
5. How would you rate your pain *at its worst*? 1 2 3 4 5 6 7 8 9 10
6. What *increases* your pain level?
7. What *decreases* your pain level?
8. Do you have pain or numbness at night? Y or N Does it awaken you at night? Y or N
9. What is your occupation? Have you missed work due to injury? Y or N
10. Have you had therapy before for this condition? Y or N

GENERAL HEALTH

1. What are your current medications?
2. Females: Are you pregnant? Y or N
3. Any previous surgeries?
4. Do you have allergies? If yes, to what? _____
5. Have you had a(n): X-Ray? Y or N MRI? Y or N Bone Scan? Y or N

PAST MEDICAL HISTORY

1.	Cancer	Y or N	8.	Diabetes	Y or N
2.	Heart Disease	Y or N	9.	Migraines	Y or N
3.	Incontinence	Y or N	10.	Arthritis	Y or N
4.	High Blood Pressure	Y or N	11.	Epilepsy	Y or N
5.	Multiple Sclerosis	Y or N	12.	Smoker	Y or N
6.	Hepatitis	Y or N	13.	Osteoporosis	Y or N
7.	Thyroid Problems	Y or N			

THE PURPOSE OF THIS FORM IS TO GET A CLEAR UNDERSTANDING OF YOUR MEDICAL CONDITION, WHICH IS HELPFUL IN SETTING UP YOUR THERAPY TREATMENT PLAN.