SPORTSCARE PHYSICAL THERAPY CENTERS

Patient Medical History Form

Name _____ **Treating Physician** _____

Primary Care Physician _____ **Date of 1st Doctors Visit for this Injury** _____

Are the injuries a result of a: ☐ Work Accident ☐ Auto Accident If so, DOA _____ ☐ N/A

Last Day Worked Due to this Injury (if applicable): _____

Date Returned to Work after Injury (if applicable): _____

Have you retained an attorney as a result of your injury? ☐Yes ☐No

Referral Source ☐Surgeon ☐Rehab ☐MD ☐Other _____

Have you had Surgery for this Injury? ☐ Yes ☐ No Number of Surgeries: _____

Type of Surgery(ies): _____

Are you currently taking any medications (prescription and/or over the counter medicines):

Anti-Inflammatories	☐YES ☐NO	If YES, please specify:	_____
Muscle Relaxers	☐YES ☐NO	If YES, please specify:	_____
Pain Medication	☐YES ☐NO	If YES, please specify:	_____
Other	☐YES ☐NO	If YES, please specify:	_____

Have you had any of the following diagnostic, medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO		YES	NO
General Practitioner	☐	☐	Emergency Room	☐	☐	EMG/NCV	☐	☐
Chiropractor	☐	☐	Podiatrist	☐	☐	MRI	☐	☐
Occupational Therapy	☐	☐	Neurologist	☐	☐	X-Rays	☐	☐
Physical Therapy	☐	☐	Orthopedist	☐	☐	CT Scan	☐	☐
Massage Therapy	☐	☐	Myelogram	☐	☐			

Do you now or have you ever had any of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	☐	☐	Elbow Injury / Surgery	☐	☐
Shortness of Breath/Chest Pain	☐	☐	Hand Injury / Surgery	☐	☐
Coronary Heart Disease or Angina	☐	☐	Dizziness or Fainting	☐	☐
Cancer/chemotherapy/Radiation	☐	☐	Numbness or Tingling	☐	☐
Emotional/Psychological Problems	☐	☐	Arthritis/Swollen Joints	☐	☐
Vision or Hearing Difficulties	☐	☐	Neck Injury/Surgery	☐	☐
Bowel or Bladder Problems	☐	☐	Weight Loss/Energy Loss	☐	☐
Sleeping Problems/Difficulties	☐	☐	Gout	☐	☐
Leg/Ankle/Foot Injury/Surgery	☐	☐	Hernia	☐	☐
Thyroid Trouble/Goiter	☐	☐	Stroke/TIA	☐	☐
Any Pins or Metal Implants?	☐	☐	Osteoporosis	☐	☐
Do you have a Pacemaker?	☐	☐	Diabetes	☐	☐
Back Injury/Surgery	☐	☐	Weakness	☐	☐
Blood Clot/Emboli	☐	☐	Epilepsy/Seizures	☐	☐
Knee Injury/Surgery	☐	☐	Varicose Veins	☐	☐
Infectious Diseases	☐	☐	Are You Pregnant?	☐	☐
Heart Attack or Surgery	☐	☐	Joint Replacement	☐	☐
High Blood Pressure	☐	☐	Do You Smoke?	☐	☐
Severe or Frequent Headaches	☐	☐	Anemia	☐	☐
Shoulder Injury /Surgery	☐	☐	Allergies	☐	☐

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Please provide details regarding the above checked conditions _____

_____

_____

_____

Please list any additional information that would assist us in providing care to you?

_____

_____

_____

_____

What are your expectations/goals?

_____

_____

_____

_____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

Patient/Legal Guardian Signature _____ **Date** _____

Patient/Legal Guardian Name _____

Therapist's Signature _____ **Date** _____