

PHYSICAL THERAPY AND DURABLE MEDICAL HEALTH HISTORY FORM

Patient Name: _____

Age: _____

Reason for today's appointment: _____

Have you had any of the following for this problem: MRI X-Ray CT Scan

Where: _____

When: _____

Have you had surgery for this problem: YES NO

Where: _____

When: _____

Surgeon: _____

Do you smoke: YES NO

Is it possible that you are pregnant: YES NO

Please list any medications you are taking:

Have you had or do have any of the following conditions:

Heart Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Strokes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Do you have any pain: YES NO

If so, where: _____

Type of pain: SHARP ACHE BURNING OTHER

Do you have any numbness or tingling: YES NO

If so, where: _____

Do you have any swelling: YES NO

If so, where: _____

Please rate your pain on a scale of 0-10. 0 Being no pain or discomfort and 10 indicates extreme pain and extreme discomfort.

0 1 2 3 4 5 6 7 8 9 10

ATTESTATION

The above information is true to the best of my knowledge.

Signature of Patient, Parent, Legal Guardian or POA

Date