KINETIC PHYSICAL THERAPY & WELLNESS

MEDICAL HISTORY FORM

Name:	Date:	Birthdate:	Age:
Referring Physician:		Phone#:	
Condition to be treated:		Date Condition Began:	

Please Check All that Apply

☐Heart	☐Diabetes	☐High Blood Pressure	☐Pacemaker
☐Cancer	☐Tuberculosis	☐Visual Impairment	☐Epilepsy
☐HIV / AIDS	☐Arthritis	☐Hearing Impairment	☐Fibromyalgia
☐Stroke	☐Asthma	☐Latex Allergy	☐Scoliosis
☐Osteoporosis	☐Hepatitis	☐Swelling Hands/Feet	☐Gout
☐Sleep Apnea	☐Anxiety/Depression	☐Raynaud's Syndrome	☐Dizziness
☐TMJ (Jaw Clenching)	☐Trouble Swallowing	☐Fainting	☐Double Vision

Other Conditions:_____

☐Yes ☐ No Have you had surgery for your condition?
☐Yes ☐ No Is condition related to an Auto Accident?
☐Yes ☐ No Is condition related to a work accident?
☐Yes ☐ No Are you working with a lawyer for your injury?
☐Yes ☐ No Have you had any injections for your condition?

Please list any diagnostic tests (ex. MRI, X-ray) you have had for this condition:

Please list any medications that you are taking:

What are your current symptoms?

How did the injury or problem occur?

Please rate your pain using a 0-10 scale (0=no pain, 10=the worst pain you can imagine)
_____ Worst pain since onset
_____ Best pain since onset
_____ Today's pain

Where is your pain or problem located?

Is your pain? ☐ Constant ☐ Intermittent ☐ Dull ☐ Sharp ☐Other _____

What makes your pain / problem better?

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What makes your pain / problem worse?		
☐Yes ☐ No Is there pain present at night? What position helps you to sleep? _____		
☐Yes ☐ No Have you had PT for this condition? Where? _____		
☐Yes ☐ No Are you currently working?	If no, how many total days of work have you missed?	
Are your work duties ☐Full ☐ Restricted	How many hours do you work per week?	
Who is your employer?	What type of work do you do?	
What activities in your daily life or work duties have been most affected by your problem?		
What do you hope to accomplish with therapy?		
Are you exercising at home?	☐Yes ☐ No	If yes, what type?
Are you using heat or cold?	☐Yes ☐ No	If yes, what type?
Are you wearing a sling or brace?	☐Yes ☐ No	If yes, what type?
Do you smoke?	☐Yes ☐ No	If yes, how much?
What type of non-work activities are you involved in?		
When are you scheduled to see your doctor again?		
Other Comments:		

To the best of my knowledge and belief, the information I have given is complete and true. I hereby give my consent to receive therapy and wellness services by the staff of Kinetic Physical Therapy and Wellness. I consent for referral to a hospital or physician for the purpose of provision of emergency medical care if indicated even if I am unable to provide permission at the time of the emergency.

_____ _____

Patient/Guardian Signature Date