Active Motion Physical Therapy
Patient Medical History

Name: _____ **DOB:** _____ **Date:** _____
Height: _____ **Weight:** _____

Are you currently taking any prescription or non-prescription medications? Yes No
If your answer is yes, please list below or provide us with a list of your medications and dosages, including frequency:
_____

Have you had any medical or rehabilitative services for the injury or problem for which you are here? Yes No
If your answer is yes, please list the type(s) of health care providers you have seen:
_____

Rate your pain level on a scale of: 0 – 10 (0 = No pain, 10=Emergency Room pain) _____

Have you fallen during the past year? Yes No
If your answer is yes, how many falls have you had? _____ Were you injured? _____

Are you worried about falling? Yes No

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

	Yes	No	
Joint Replacement	___	___	Where/When? Knee _____ Shoulder _____ Hip _____
Pins or metal implants	___	___	Where? _____
Heart Attack	___	___	When? _____
Heart Surgery	___	___	When? _____
Other Surgery	___	___	Where/When? _____
Cancer	___	___	Where/When? _____
Stroke/TIA	___	___	When/What areas affected? _____
Vision difficulties	___	___	
Hearing difficulties	___	___	
Heart Disease	___	___	
High Blood Pressure	___	___	
Chest Pain	___	___	
Blood Clot/Emboli	___	___	
Pacemaker	___	___	
Arthritis	___	___	
Diabetes	___	___	
Asthma, Emphysema	___	___	
Thyroid disease/Goiter	___	___	
Sleeping difficulties	___	___	
Bladder or bowel problems	___	___	
Headaches	___	___	If yes, frequency/severity _____
Numbness or tingling	___	___	If yes, where? _____

	Yes	No
Are you pregnant?	___	___
Do you use tobacco?	___	___
Dizziness or Fainting	___	___
Fibromyalgia	___	___
Epilepsy/Seizures	___	___
Osteoporosis	___	___
Anemia	___	___
Shortness of Breath	___	___
Hernia	___	___
Gout	___	___
Weight loss/Energy loss	___	___
Weakness – Where? _____		

Infectious diseases _____
Allergies _____

What are your rehabilitation expectations/goals? _____

List any other information that would assist us in your care: _____

Patient/Guardian Signature: _____

Revised 1/7/16