PROFESSIONAL
Life in Action

PATIENT MEDICAL HISTORY FORM

Name: _____ **Treating Physician:** _____
Primary Care Physician: _____ **Date of 1st Doctors Visit for this Injury:**_____
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
Chiropractor	____	____	General Practitioner	____	____
EMG/NCV	____	____	CT Scan	____	____
Massage Therapy	____	____	MRI	____	____
Myelogram	____	____	Neurologist	____	____
Occupational Therapy	____	____	Orthopedist	____	____
Physical Therapy	____	____	Podiatrist	____	____
Emergency Room	____	____	X-Rays	____	____

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

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	High Blood Pressure	____	____
Anemia	____	____	Shortness of Breath/Chest Pain	____	____
Heart Attack or Surgery	____	____	Diabetes	____	____
Coronary Heart Disease or Angina	____	____	Thyroid Trouble/Goiter	____	____
Gout	____	____	Cancer/chemotherapy/Radiation	____	____
Dizziness or Fainting	____	____	Weakness	____	____
Emotional/Psychological Problems	____	____	Infectious Diseases	____	____
Hernia	____	____	Bowel or Bladder Problems	____	____
Numbness or Tingling	____	____	Allergies	____	____
Severe or Frequent Headaches	____	____	Elbow/Hand Injury	____	____
Osteoporosis	____	____	Vision or Hearing Difficulties	____	____

	YES	NO		YES	NO
Neck Injury/Surgery	____	____	Stroke/TIA	____	____
Sleeping Problems/Difficulties	____	____	Back Injury/Surgery	____	____
Blood Clot/Emboli	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Knee Injury/Surgery	____	____	Epilepsy/Seizures	____	____
Do you have a Pacemaker?	____	____	Arthritis/Swollen Joints	____	____
Varicose Veins	____	____	Any Pins or Metal Implants?	____	____
Are You Pregnant?	____	____	Joint Replacement	____	____
Weight Loss/Energy Loss	____	____	Do You Smoke?	____	____

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

_____

_____

Are you aware of your diagnosis (what you are being treated for at our clinic)? Yes No

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: _____