Physical Therapy & Sports Medicine
www.GetBacktotheGameofLife.com

PATIENT MEDICAL HISTORY

Name: _____ **DOB:** _____

Reason for your visit today? _____

How did this incident/injury occur? _____

Date this injury occurred? _____ **Auto accident? Y N** **Work injury? Y N**

Was surgery performed for this injury? If so, give date: _____

Current level of pain: (NONE) 0 ___ 1___ 2___ 3___ 4___ 5___ 6___7___8____9___10___ (EXTREME)

Activities that increase your pain: _____

MEDICAL HISTORY

Conditions you currently have: (please circle)

Pregnant	**Y**	**N**	**Latex allergies**	**Y**	**N**
High Blood pressure	**Y**	**N**	**Pacemaker**	**Y**	**N**
Heart condition	**Y**	**N**	**Seizures**	**Y**	**N**
Stroke	**Y**	**N**	**Cancer**	**Y**	**N**
Diabetes	**Y**	**N**	**Arthritis**	**Y**	**N**
Osteoporosis	**Y**	**N**	**Head Trauma**	**Y**	**N**
Head or spine surgery	**Y**	**N**	**Fractures**	**Y**	**N**

List all medications you take for this condition: _____

_____

List any surgical procedures done in the past 5 years: _____

_____

List activities that you do on a regular basis (running, swimming, etc.) _____

_____

List activities that you have stopped as a result to this injury: _____

_____

Name of referring physician: _____ **Phone #:** _____

Signature: _____ **Date:** _____