Patient Medical History

CBPT
Sports and Orthopedic Physical Therapy

Personal Information

Name: _____ *DOB:* ____/____/____ *Age:* _____ *Race:* _____

Primary Language: ☐ *English* ☐ *Spanish* *Other:* _____

Primary Phone Number: _____ *Alternate Phone Number:* _____

Current Condition

What concern(s) bring you to physical therapy? _____

When was the onset of your injury or pain? _____

For this condition, what other healthcare professionals have you seen? _____

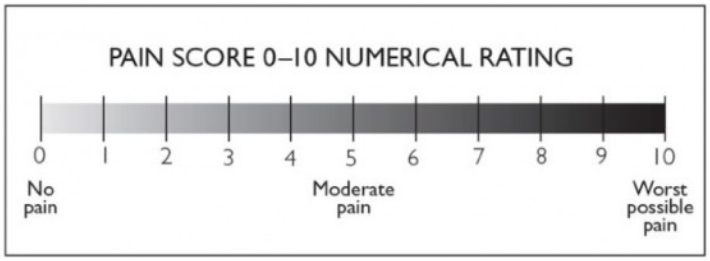
For this condition, have you had any imaging or testing? _____

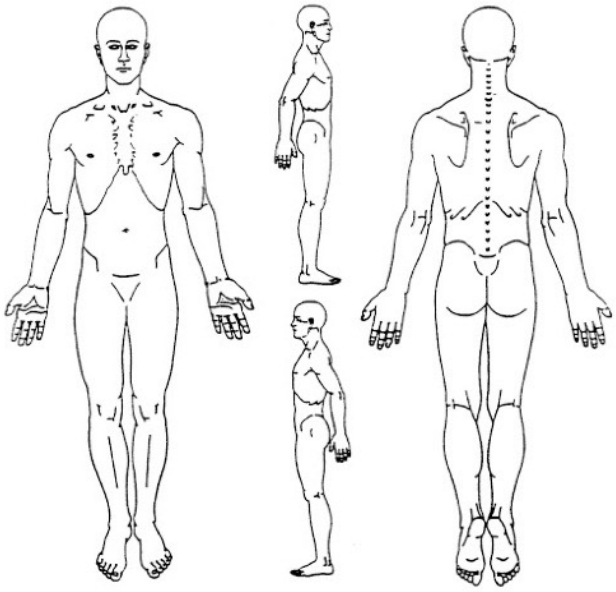
Put an "X" anywhere on the diagram that you are having pain

Current Pain: *0 1 2 3 4 5 6 7 8 9 10*

MOST pain in the last week: *0 1 2 3 4 5 6 7 8 9 10*

LEAST pain in the last week: *0 1 2 3 4 5 6 7 8 9 10*





Social History

Are you currently employed? ☐ *Yes* ☐ *No* *If yes, what is your Occupation?* _____

Living arrangements: ☐ *Live alone* ☐ *Live with family/significant other* ☐ *Live with roommates*

Are there any steps in your home? ☐ *Yes* ☐ *No* *Do you have difficulty sleeping?* ☐ *Yes* ☐ *No*

Have you ever been diagnosed with depression? ☐ *Yes* ☐ *No*

Do you exercise regularly? ☐ *Yes* ☐ *No* *Frequency: Days/Week* _____ *Minutes/Day* _____ *Intensity* _____

Do you smoke? ☐ *Yes* ☐ *No* *If yes, Packs/Day* _____

Do you drink alcohol? ☐ *Yes* ☐ *No* *If yes, Drinks/Day* _____

Do you have any cultural or religious beliefs we should be aware of? ☐ *Yes* ☐ *No* *If yes, explain:* _____

_____

Medical History

Please check any of the following medical conditions that you've been diagnosed with:

☐ *Heart Disease* ☐ *Heart Attack* ☐ *Heart Palpitations* ☐ *Chest Pain Angina*

☐ *High Blood Pressure* ☐ *Pacemaker* ☐ *Skin Abnormalities*

☐ *Diabetes* ☐ *Type 1 Juvenile* ☐ *Type 2 Adult Onset* *Do you take insulin?* ☐ *Yes* ☐ *No*

☐ *Asthma Breathing Difficulties* *Do you use a rescue inhaler?* ☐ *Yes* ☐ *No*

☐ *Headaches* ☐ *Dizziness/Fainting* ☐ *Ringing in your ears* ☐ *Seizures*

☐ *Kidney Problem* ☐ *Cancer* ☐ *Hernia* ☐ *Special diet guidelines*

☐ *Bowel/Bladder abnormalities* ☐ *Liver/Gallbladder abnormalities* ☐ *Nausea/Vomiting*

☐ *Recent Fractures* ☐ *Recent Surgery* ☐ *Metal Implants* ☐ *Rheumatoid Arthritis*

☐ *Sexual Dysfunction* ☐ *Other Medical Conditions* _____

Allergic to: ☐ *Aspirin* ☐ *Latex* ☐ *Heat* ☐ *Cold* ☐ *Medications:* _____

List any Surgeries: _____

List any Hospitalizations: _____

Are you currently taking any prescription or over-the-counter medication for any of the following conditions?

☐ *Inflammation* ☐ *Heart Condition* ☐ *Lung Condition* ☐ *Sleep Condition* ☐ *Depression*

☐ *Stomach/GI Condition* ☐ *Seizures* ☐ *Skin Condition* ☐ *Genito-urinary Condition*

☐ *Psychiatric Condition* ☐ *Vitamins* ☐ *Supplements* ☐ *Pain*

Please list all medications and dosages: _____ _____

_____ _____

Family History

Has anyone in your immediate family been diagnosed with any of the following:

☐ *Diabetes* ☐ *Heart Disease* ☐ *High Blood Pressure* ☐ *Stroke* ☐ *Cancer*

☐ *Alcoholism* ☐ *Depression* ☐ *Kidney Disease* ☐ *Inflammatory Arthritis*

I acknowledge that the information above is accurate to the best of my knowledge.

Patient Signature: _____ *Date:* _____

Physical Therapist Signature: _____ *Date:* _____