GOIN BEYOND
PHYSICAL THERAPY

CONFIDENTIAL MEDICAL HISTORY

Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU

Full Name _____ **Date of Birth** ___ /___ /_____

EMAIL ADDRESS: _____

To receive our monthly newsletter and special updates. Please check here. You can unsubscribe at any time. ❑

Primary Care Physician _____ **Referring Physician** _____

Who did you hear about us? _____

What is your major complaint? _____

_____

Is this condition: ❑**Job related** ❑**Auto Accident** ❑**Home injury** ❑**Other:**_____ **Date of accident** ___/___/_____

Date of Onset/Condition? _____**What caused this condition?** _____

Does anything make this condition feel worse? _____

Does anything make this condition feel better? _____

Is this condition interfering with your: ❑**Work/School** ❑**Sleep** ❑**Daily Routine** ❑**Other:**_____

Is this condition: ❑**Improved** ❑**Unchanged** ❑**Getting Worse**

Other Doctors or Therapist who have treated <u>THIS</u> Condition (Please Provide Names)**:**_____

List surgical operations and years: _____

Medications, dosage and frequency: _____

_____

Have you had this or similar conditions in the past? ❑**Yes** ❑**No** **If Yes, Why?**_____

Social History:

Current Weight_____ **Current Height** _____

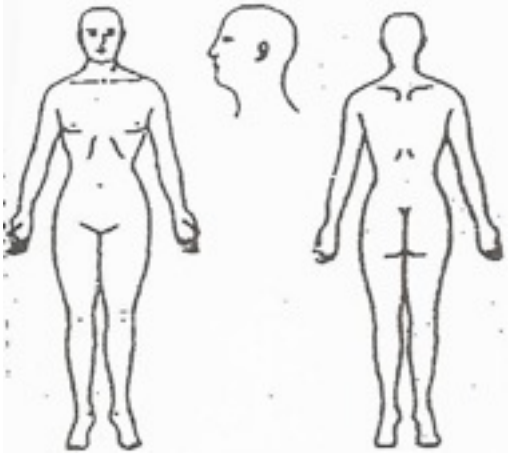
PLEASE CIRCLE: 1 being no pain 10 being severe pain.

Pain level at worst: 1 2 3 4 5 6 7 8 9 10

Pain level currently: 1 2 3 4 5 6 7 8 9 10

Pain level at best: 1 2 3 4 5 6 7 8 9 10

MARK THE AREAS OF YOUR SYMPTOMS ON THE FIGURES BELOW



GOIN BEYOND
PHYSICAL THERAPY

CONFIDENTIAL MEDICAL HISTORY (Continued)

Full Name _____

MEDICAL HISTORY

High Blood Pressure	❑Yes ❑ No	Kidney Problems	❑Yes ❑ No
No Cardiac Condition	❑Yes ❑ No	Liver Problems	❑Yes ❑ No
Heart Attack	❑Yes ❑ No	Cancer	❑Yes ❑ No
Circulation Problems Pacemaker	❑Yes ❑ No	Nervous Disorders	❑Yes ❑ No
Seizures	❑Yes ❑ No	Vision Problems	❑Yes ❑ No
Dizzy Spells	❑Yes ❑ No	Sensitivity to Heat/Cold	❑Yes ❑ No
Diabetes	❑Yes ❑ No	Metal Implants	❑Yes ❑ No
Allergies	❑Yes ❑ No	Are you Pregnant?	❑Yes ❑ No
Fractures	❑Yes ❑ No	Arthritis	❑Yes ❑ No
Stroke	❑Yes ❑ No	Lung Issues	❑Yes ❑ No
Autoimmune Disorder	❑Yes ❑No	Blood Clots	❑Yes ❑No
Multiple Sclerosis	❑Yes ❑No	Depression	❑Yes ❑No

Additional details regarding your conditions:

_____

_____

_____

_____

*Signature of Patient/Parent or Legal Guardian*_____*Date* _____