THE · PT pct CENTER

Patient Name: _____ **Date:** _____

PATIENT MEDICAL HISTORY

PLEASE MARK IF YOU HAVE/ HAD ANY OF THE FOLLOWING:

____ Pacemaker/ Defibrillator
____ History of Cancer
____ Bowel or Bladder Problems
____ Dizziness or Fainting
____ Pregnancy
____ Latex Allergy
____ Previous Accidents
____ Diabetes
____ Epilepsy/ Seizures
____ Scoliosis
____ Blood Clots/ Emboli
____ Stroke
____ Heart Attack
____ Pulmonary/ Respiratory

CHECK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

____ Osteoporosis
____ Tingling/ Numbness
____ Headaches
____Pain with coughing or sneezing
____ Shortness of Breath
____ Anxiety/ Panic Disorders
____ Unusual Weakness
____ Difficulty Sleeping
____ Unexplained weight loss
____ Balance Problems
____ Circulatory Problems

ADDITIONAL CARE FOR THIS INJURY (Please name, date and results as appropriate):

General Practitioner: _____
Xray: _____
MRI: _____
Orthopedic Specialist: _____
Physical Therapist: _____
Neurologist: _____
Chiropractor: _____
Occupational Therapist: _____
EMG/NCV: _____
ER: _____

Have you been treated by a chiropractor/ other physical therapist this year? If so, where and for how long?

_____

PLEASE LIST ANY MAJOR SURGERIES AND HOSPITALIZATIONS (within the last 2 years)

_____ Date: _____

_____ Date: _____

CURRENT MEDICATIONS (Please list including prescription, over the counter, herbals, vitamin/mineral/ dietary supplements, including drug name, dosage, frequency):

Anti-infammatory: _____
Pain: _____
Muscle Relaxers: _____
Other: _____
_____
_____

DO YOU SMOKE? YES / NO If Yes, how many packs per day? _____

DO YOU CONSUME CAFFINATED BEVERAGES DAILY? YES / NO If Yes, how many? _____

ANY KNOWN ALLERGIES _____

On a pain scale from 0 to 10 (0 being no pain at all - 10 being severe pain) how would you rate your pain currently?

0 1 2 3 4 5 6 7 8 9 10

Have you fallen in the past year? Yes No **If so, how many times have you fallen in the past year?** _____

If you have fallen, did it result in an injury? Yes No