

Peak Physical Therapy and Sports Medicine Center

Patient Medical History

Name: _____ Referring Physician: _____

Primary Care/Family Physician (if different from referring physician): _____

Date of first doctor visit for this injury (i.e. How long have you had this problem): _____

Is this injury due to a Motor Vehicle Accident or a Worker Compensation Claim: Y or N

If applicable, when was the last date worked due to this injury: _____

Is an attorney involved in this case: Y or N If YES, please give name and phone number: _____

Have you had surgery pertaining to this injury or any type of cardiac surgery: Y or N

If YES, what type: _____

List any medications you are currently taking: _____

Have you had any of the following services for this injury?

	Yes	No		Yes	No
Physical Therapy	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Chiropractor	___	___	Neurologist	___	___
Emergency room Care	___	___	Orthopedist	___	___

Other: _____

Do you have or have you had any of the following:

	Yes	No		Yes	No
Asthma, Bronchitis, Emphysema	___	___	Severe Headaches	___	___
Shortness of breath / Chest pain	___	___	Vision / Hearing problems	___	___
Heart Disease / Angina	___	___	Numbness / Tingling	___	___
Do you have a Pacemaker	___	___	Dizziness or Faintness	___	___
High Blood Pressure	___	___	Weakness	___	___
Heart Attack	___	___	Weight Loss / Energy Loss	___	___
Stroke / TIA	___	___	Hernia	___	___
Blood Clot	___	___	Varicose Veins	___	___
Epilepsy / Seizures	___	___	Allergies	___	___
Anemia	___	___	Any pins / metal implants	___	___
Infectious Diseases	___	___	Joint Replacement	___	___
Diabetes	___	___	Neck Injury / Surgery	___	___
Cancer or Chemotherapy / Radiation	___	___	Shoulder Injury / Surgery	___	___
Arthritis / Swollen Joints	___	___	Elbow / Hand Injury / Surgery	___	___
Osteoporosis	___	___	Back Injury / Surgery	___	___
Sleeping Problems	___	___	Knee Injury / Surgery	___	___
Emotional / Psychological Problems	___	___	Leg / Ankle Injury / Surgery	___	___
Bowel or Bladder Problems	___	___	Do you smoke	___	___
Are you pregnant	___	___			

List any other information that would assist us in your care: _____

What are you expectations / goals while in Physical Therapy: _____

Patient / Guardian Signature

Date