IMPACT
PHYSICAL THERAPY

Past Medical History

Patient Name:____ Age: _______ Sex : F____ M ____

What is your main complaint and in what area is it located?____
____

Occupation: ____Are you presently working? Yes No

If no—Last Day Worked: ___________________________

Have you ever had these symptoms before? Yes No If yes, When? ______________________________

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes No

Which one and when? ____

Check all of those which apply to your current condition:

Work Related Injury | Sports Injury | Motor Vehicle
Accident | Aggravation of Pre-Existing Injury | Causes Unknown
Injury Recurrence | Lifting Injury | Fall

What have you been doing to decrease your pain? ____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? ____________________

Are your symptoms getting worse/ better/ the same/ since your injury? ____________________________________

Are you currently taking any medications? (Please list) ____
____

Are you allergic to any medications? (If yes, please list) ____
____

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

Diabetes | Cancer | Metal Implants | Headaches | Nausea/Vomiting
Chest Pain | Asthma | Dizziness | Kidney Problems | Ear Ringing
Heart Disease | Arthritis | Fractures | Bladder Problems | Hypoglycemia
Pacemaker | Aids/HIV | Skin Allergies | High Blood Pressure | Seizures
Allergies to Cold | Allergies to Heat | Respiratory Problems

Are You Pregnant Yes No

If you answered yes to any of the above, please explain and give an approximate date of occurrence: _______________
____

Please **circle** tests you have had performed: None X Rays MRI CT Scan Bone Scan Other______

Check any of the following activities which you have difficulty with due to your injury:

Housekeeping | Lifting | Driving | Shopping | Reaching
Dressing | Cooking | Climbing Stairs | Child Care | Bending
Yard Work | Sit to Stand

List all of your surgeries: ____
Is there any other information about your present health that we should know about? ___________________________

_________________________ _____________________________ __________

Date Patient Signature PT/OT Initials